1 APRIL 2000

# CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY



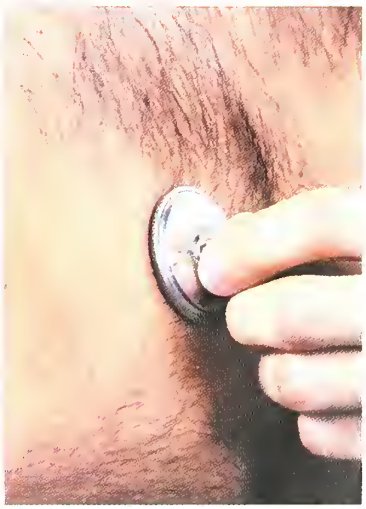
## *LPC anger over pharmacist for care homes*

*New source funds £60k for supervised methadone scheme*

*Romanes highlights major changes for Scottish contractors*

*AAH attracts record number to Dubai*

*Phoenix makes agreed bid for Norscot*



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# CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

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## REGULARS



## COMMENT

How much longer will the Health Service tolerate protectionism? The Prime Minister has called for an end to demarcation between the professions, but how about an end to demarcation within a profession? A case in point is that of the Isle of Wight. Pharmacy contractors there are up in arms as they are about to loose £30,000. But the money is staying within pharmacy because the Health Authority has decided to replace the existing nursing and domiciliary homes service with a full-time pharmacist employee. When it is the patients' best interests that are at stake, it certainly makes sense to have a specialist pharmacist who is able to tend specifically to the elderly in care homes, much like a ward pharmacist in hospital. Meanwhile, the community pharmacists can concentrate on serving the rest of the community.

But hang on. Over two thirds of the Island's pharmacies are involved in serving the 100 plus homes on the island by providing three visits a year plus additional advice. Can one employee really improve on the service already provided? Wight is not exactly small and it is acknowledged that the new scheme may not be entirely cost-effective.

In this era of limited resources, is the Isle of Wight (with its significantly elderly population) so replete with cash that it can afford to have a few odd inefficiencies here and there? After all, the unified budget means that an overspend in one area can always be corrected with a forced underspend elsewhere. Alas, with the devolution of monies for pharmaceutical services from the global sum to a local level, and the ending of ring-fencing, the Government will be able to wash its hands and say: "It's not our fault - the money was there." What may have been an experiment in restructuring local health services could turn out to be a very expensive mistake. It also serves to demonstrate how vulnerable community pharmacists are to changes in NHS service arrangements.








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Miller Freeman

PPA ABC

## Views sought for oxygen review

The NHS Executive is seeking opinions on the supply of domiciliary oxygen in England, including whether pharmacists should continue to dispense cylinders.

The review will consider:

- what forms of oxygen (cylinder, concentrator or liquid) should be available in the domiciliary service and when one form might be better than another
- whether GPs should prescribe oxygen or if this should be done, as in Scotland, by hospital respiratory physicians.
- whether the service should be reorganised so that cylinders, concentrators and liquid oxygen are all supplied under contract
- whether the arrangements for setting prices should be maintained
- the cost-effectiveness and affordability of any changes
- areas in which savings could be made.

This preliminary review follows last summer's report from the Royal College of Physicians on domiciliary oxygen therapy services (*C&D* July 31, 1999). Depending on the opinions expressed this time around, the DoH may carry out formal consultations.

Views should be sent to Jenny Mudge, Department of Health, Room 168, Richmond House, 79 Whitehall, London SW1A 2NS, to arrive by May 12.

# IoW LPC angry as HA employs 'nursing home' pharmacist

The Isle of Wight Local Pharmaceutical Committee has reacted angrily to a decision by its Health Authority to replace existing community pharmacy services to nursing and residential homes with a full-time appointee.

The LPC is warning pharmacy contractors elsewhere that they could face a similar threat. The service, with a budget of £30,000, is provided by over two-thirds of the Island's 30 pharmacies, but will end in four months' time.

A full-time Health Authority appointed 'pharmacist for the elderly' will then be responsible for the 105 care homes on the island. It is believed the new scheme will be cost negative, at an estimated cost nearer £36,000. Adverts for the new position will be placed in the next couple of weeks.

The change has come as money for care home services, which has been devolved from the global sum paid for pharmaceutical services, ceases to be ring-fenced this month. Currently contractors are paid £400 per nursing home and £240 per residential home for their services.

Besides homes being denied a choice of service provider, LPC chairman David Croucher believes that to provide the current level of service will require up to four full-time equivalents.

Last week, Mr Croucher asked the HA board: "If you were not satisfied over the past ten years with the service my colleagues and I provided, why have you said or done nothing?"

He told *C&D* this week: "It was plain to see that, even prior to my presentation, every member had been lobbied and sold the idea. We would be perfectly happy to put in place an audit system," he added.

Part of the problem stems from legal advice taken by the Pharmaceutical Services Negotiating Committee, says Mr Croucher. PSNC was persuaded that the HA would not be able to switch the budget in this way.

However, the HA has argued that the new legislation is permissive, not directive, allowing it to employ a pharmacist to provide a care home service in place of the service provided by contractors.

Noel Staunton, prescribing manager for the HA and the primary care group, thinks his HA may be the first to end the advisory pharmacist model and take on a full-time pharmacist for care homes.

The position is being created as the HA wants to move towards a more clinically-orientated service, he said. "We are not critical of the existing service ... but we do not think they have the time or clinical expertise to do a full medical evaluation and then talk with the home and the GP."

The HA is aware of concerns being raised by the homes, social services and GPs about medicines ordering, usage, and polypharmacy.

Mr Staunton argues that hospitals have ward pharmacists who review individual patients' medication on a daily basis. "In homes, patients tend to be on more medication. They are the most vulnerable patients and their medication requirements are greater than other [patient groups]."

Mr Staunton acknowledges that pharmacists will lose income. As pharmacies are limited to a maximum of eight homes, their income will fall by a maximum of £3,000. The multiples, particularly Boots, will be affected most.

He hopes that other initiatives taking place will help compensate for the loss of providing nursing homes services. Among these are: paying community pharmacists to work with their local practice on a regular ongoing basis, and advocating a 28-day prescribing cycle, which has already been adopted by several large practices.

## Pharmacist to chair South Humber HA

Pharmacist Madeleine Keyworth is to be chairman of South Humber Health Authority with effect from April 1.

She has played a prominent role in pharmacy education and the NHS in the north Lincolnshire area, as well owning her own pharmacy. Her involvement with the NHS started when she became a member of Scunthorpe District HA, and later Humberside FHSA.

**Madeleine Keyworth, who owned a community pharmacy in Cleethorpes from 1980 to 1994**

# NPA votes against POM to P switch for EHC

The National Pharmaceutical Association Board has voted not to support proposals to deregulate emergency hormonal contraception (EHC) to Pharmacy medicine status.

Meeting this week, the Board supported the view that while pharmacists should be able to supply EHC, it should be available free of charge within protocols, rather than being sold as a P medicine.

Making EHC products P medicines would create an inequality in health services, says the NPA. Patients would be able to get EHC free from GPs, clinics or under pharmacy protocol schemes such as the one running in Manchester, but would have to pay for the P product through pharmacies. Keeping EHC products within protocols would also mean that there would be a written record of the supply.

The Manchester and Salford scheme is proving a success, and a similar scheme is about to start in the Lambeth, Southwark & Lewisham Health Authority. Other schemes may soon start elsewhere in London and in Derbyshire.

NPA director John D'Arcy argues that using protocols will involve community pharmacists more in the NHS, and could be a way to develop the anticipated prescriber status for the profession. "As a first step, protocols can show that pharmacists have something serious to offer," he said.

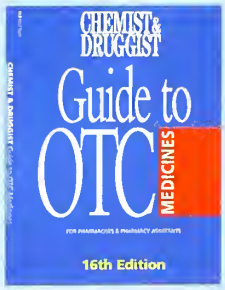
The NPA will respond to the Medicines Control Agency consultation on the proposal to switch Levonelle 2 from POM to P status. Normally, pharmacists have been keen for such switches, but Mr D'Arcy argues that EHC has to be looked on as a special case. There is also the question of inequality of access as contraception in the NHS has always been free.

"We need to think a little more carefully about whether it should be kept as a POM," he said. "It's not just about supplying a product, we also believe it should be seen as part of a sexual health strategy."

## Guide to OTC Medicines published this week

**The 16th edition of the *Chemist & Druggist* 'Guide to OTC Medicines' is published this week. The Guide contains information on licensed branded medicines intended for promotion over the counter. It also contains sections listing branded licensed herbal and homoeopathic remedies.**

**Community pharmacy subscribers should receive a copy of the Guide free with this issue. Additional copies are available to *C&D* subscribers at £7.50 per copy or to non-subscribers at £10 per copy. Prices include postage and packing. Please send in a cheque made payable to 'Miller Freeman UK Ltd' to Jan Pawis, *C&D*, Miller Freeman House, Sovereign Way, Tonbridge, Kent TN9 1RW.**



## IN BRIEF

**It's April 1: script levy increase**

NHS prescription chorges go up on April 1 to £6 per item or £12 per poir of onklets, kneecops or stockings. Pre-poyment certificotes ore £31.40 for four months ond £86.20 for 12 months. Stotutory Instruments 620, 'The NHS (Chorges for Drugs ond Applionces) Regulotions 2000', ond Stotutory Rule 52, 'Chorges for Drugs ond Applionces (Amendment) Regulotions (Northern Irelond) 2000', were published this week.

**LPC representative**

Kensington, Chelseo & Westminster Locol Phormoceuticol Committee's motion wos presented by Tony Corson ot the LPC Conference in Morch, ond not os reported in lost week's *C&D* (p25).

**Licence fees increase**

Regulotions coming into effect on April 1 increose fees for medicines morketing outhorisotions ond licences. The Medicines for Humon Use ond Medicol Devices (Fees ond Miscelloneous Amendments) Regulotions 2000 (SI No 592 £2) olso increose fees poyoble for homoeopothic medicines.

**Remuneration from trusts**

From April 1 NHS trusts ond primory core trusts ore obliged to reimburse heolth outhorities for the cost of medicines or opplionces ordered by the trusts' doctors or dentists for dispensing in the community. The requirement is mode under the NHS Trusts ond Primory Core Trusts (Phormoceuticol Services Remunerootion – Speciol Arrongement) Order 2000 (Englond) (SI No 595; Stotionery Office, £1).

# No national CPD scheme before 2002

A national continuing professional development programme for pharmacists is unlikely to be in place before 2002, says Fred Ayling, the Royal Pharmaceutical Society's CPD adviser.

The results of the Society's CPD pilot, involving 500 pharmacists in four areas, will be put to the RPSGB's Council meeting in October. Council will then decide whether to introduce the scheme nationwide.

Mr Ayling told a meeting on Monday it was too early to say what a national framework might look like or how it might be regulated. Increasing public expectations and the introduction of clinical governance had begun to make redundant the issue of whether or not CPD should be mandatory. Council would bear these drivers in mind when making its decision. The main issue was one of quality.

While pharmacists generally had a positive attitude towards their development, these attitudes could not be forced and there was an understandable element of fear if CPD was linked to continued registration.

Pharmacists might record what they thought the Society would want to hear rather than what they had done or needed to do. For this reason, the pilot had incorporated the identification of skills gaps, and incident analysis (looking at how the pharmacist coped with good as well as bad events).

CPD monitoring would be essential if the scheme was to have any credibility with the public. In one model under discussion, pharmacists undertaking CPD would be able to show a logo and a certificate in the pharmacy.

The Society would monitor CPD records over a five-year cycle, with 20 per cent seen every year. Those with unsatisfactory records would be monitored more closely and the ultimate sanction would be removal from the register.

Mr Ayling was speaking at a meeting for pharmacist, optometrist and dental nurse education leaders, organised by the North London Education and Training Consortium.

# Pharmacist obtains £60k for methadone scheme

Grimsby pharmacist Tim Cottingham has obtained £60,000 to provide a supervised and monitored methadone service (SuMMS) over two years.

The money has come from the Single Regeneration Budget and will fund 50 places in north-east Lincolnshire. This covers Grimsby, Cleethorpes and Immingham.

Mr Cottingham, who operates Freelance Needle Exchange, made the bid jointly with South Humber Health Authority. The £28,000 available in the first year and £32,000 in the second means participating pharmacists will receive £1.50 per patient supervised per day. They will also have to submit a weekly report to prescribers.

Mr Cottingham was encouraged by the HA to make the bid as normal funding sources were limited. The NE Lincs Council provided an electronic bid template and advised on completing the bid. Mr Cottingham attended an SRB board meeting before the money was allocated.

Now the money is available, Mr Cottingham will be writing to all pharmacies in NE Lincs as well as other methadone suppliers to find out their level of interest in taking part in SuMMS.

"Those who are providing a responsible methadone service know that it is a lot of work," he said. "I hope that the vast majority of pharmacists providing a methadone service will subscribe to this so the work will be shared out. I would like as many as possible to take part."

Mr Cottingham (above) believes that 50 places will be sufficient as patients in the scheme will be expected to 'move through' and not require supervising after a few months. "The thing is to move people through – we do not want the same people consuming methadone on site on a daily basis for the two years."

**Peter Jenkins, a community pharmacist from Abercynon, NPA Board member and past chairman, was up before the Prince of Wales in Cardiff last week to be invested with his MBE, announced in the New Year Honours List. He and his wife Mary (above) were joined at the ceremony in the Banqueting Hall at Cardiff Castle by, among others, the entertainer Max Boyce and the athlete Colin Jackson. There was no champagne in sight at the investiture, said Mrs Jenkins, but they made up for it at the St David's Hotel afterwards!**

# Society director joins Pharmalife panel

The Royal Pharmaceutical Society director of professional standards, Sue Sharpe, is to act as an adviser to the business-to-business e-commerce company Pharmalife.

It is not known whether she will be paid for her services. Pharmalife chief executive Musa Dhalla could only say on Tuesday that: "We have not agreed any offer of remuneration with her."

However, Mr Dhalla acknowledges there may be concerns about possible conflicts of interest between Mrs Sharpe's role at the Society and the commercial operations which Pharmalife is planning.

The panel members have been appointed in their individual capacities, he said. "We recognise that Sue Sharpe's first and foremost responsibility is to the profession."

Mrs Sharpe has been appointed alongside Dr Alison Blenkinsopp, professor of pharmacy practice at Keele University and Richard Jackson, vice president Europe of Health Networks for IMS Health.

On Tuesday, Mr Dhalla commented: "We are looking to the panel to provide us with directional advice about things both current and in the future that pharmacists will be requiring from the new media. We also see a value in having a group of critical advisers to help maintain the quality of the products we are providing."

## Inquiry supports pharmacy on drug misuse proposals

An independent inquiry has called for legal changes to allow pharmacists more discretion in dealing with drug misusers.

It supports recommendations made by the Royal Pharmaceutical Society to solve practical problems with instalment dispensing.

A report of the inquiry, set up by the Police Foundation in 1997, says: "Pharmacists face many difficulties with customers, especially when they present incorrectly written prescriptions. They, therefore, need a more relevant legal framework that allows them to exercise professional judgement when dealing with trivial or clerical errors or omissions in prescriptions for Controlled Drugs."

The report asks the Government to give urgent and sympathetic consideration to the Society's proposals, which included recommendations that pharmacists should be able to amend instalment prescriptions after contacting the prescriber and that 14 days should be the maximum treatment on any prescription for drug misusers.

The report also supports the Society's recommendation that other drugs liable to misuse, such as benzodiazepines, should be available in instalments. Pharmacists should be able to sell injecting paraphernalia, as well as syringes, that help make injecting safer, although there should still be scope for prosecuting serious cases of sale of drug administration equipment.

The inquiry also recommends that:

- heroin, cocaine and its derivative 'crack' should remain as Class A drugs, reflecting their exceptionally powerful, addictive potential
- buprenorphine (except in combination with naloxone) should move up from Class C to Class B
- prison should no longer be a penalty for possession of Class B and C drugs
- there should be a rapid shift of resources towards treatment services
- doctors should be encouraged to prescribe the benzodiazepines and non-benzodiazepine alternatives
- the Government should encourage the development of benzodiazepines combined with an antagonist, such as flumazenil.

The Home Office was not persuaded that the classification or overall legal framework for LSD, ecstasy or cannabis should be changed. However, "there are many other recommendations which we consider are worth exploring in more detail," it said.

*'Drugs and the law', the Police Foundation, 1 Glyn Street, London SE11 5RA (tel: 020 7582 3744).*

# PSNC gives advice on consortia pharmacies

The Pharmaceutical Services Negotiating Committee has published guidance for contractors considering setting up consortia pharmacies.

A consortium pharmacy is likely to fall into one of two categories:

- if a new health centre or movement of GP practices were to draw patients from several existing pharmacies, the proprietors might wish jointly to establish a pharmacy nearby and allocate shares in proportion to the potential loss of business from their own pharmacies. The consortium would either be a new pharmacy, which would need to prove it was 'necessary or desirable' to obtain a contract, or a pharmacy established by a minor relocation of one of the existing outlets
- pharmacies likely to be affected by a new health centre might apply for a consortium to deter other contract applications, including those from outside the locality.

But there are economic drawbacks, the document warns. Firstly, a consortium involves the proprietors of existing pharmacies in extra expense without any increase in turnover. Secondly, the consortium is likely to handle more prescriptions than any of the existing pharmacies but, because of the way the professional allowance works, the income per prescription in the consortium will be less. The overall result will be reduced profit from dispensing, fewer prescription patients visiting existing pharmacies and a loss of OTC sales. The consortium itself may result in an existing pharmacy becoming unviable.

The decision to set up a consortium should ultimately be taken by the proprietors of the affected pharmacies, but years of competition means it would not always be easy to bring them together. So it is important to seek the local pharmaceutical committee's involvement as soon as possible, says PSNC. The LPC should encourage the health authority and local primary care groups and trusts to keep it informed of plans for any new medical facilities.

Before a final decision is reached, a forecast trading account for the first year should be prepared to give an idea of the consortium's likely viability and profitability. A draft format is provided in the guidelines.

Once the affected contractors have agreed in principle to apply for a consortium, they should submit their application to the health authority without delay. If one participant is to relocate a pharmacy as the future consortium, an independent solicitor should prepare the participant's agreement before the application is submitted.

The guidelines include a draft memorandum and articles of association for the consortium company, setting out how the shares and profits should be decided, and who the directors should be. It is common to divide the profits in proportion to the dispensing losses, or anticipated losses, suffered by the existing pharmacies. This allocation could be based initially on the dispensing figures in the six months before opening and reviewed, perhaps, after the first year. The shares may or may not be distributed in the same ratio. If shares are distributed equally, but profits not, all members get equal voting rights and contribute equally to the share capital, but not necessarily to the loan account.

The guidance also gives advice on raising capital and what to do if a member dies, retires or closes the business. The document was put together following a resolution at last year's LPC conference.

## SHTAC to be renamed

The Scottish Health Technology Assessment Centre, the Scottish equivalent of NICE, is to open for business in May after a name change to the Health Technology Board for Scotland.

The new body is to have the status of a special heath board and will have a management board with appointed non-executive members. The management board will be supported by a core staff of 12 led by a director and an "advisory council", Dr Angus Mackay told a meeting of the Royal Pharmaceutical Society in Edinburgh last week. This council will be "widely representative and will include representation from the professions and the public".

The new body will not restrict its investigations to new drugs, but will also examine existing therapies, medical devices and "healthcare settings".

Dr Mackay said that the new body would be "quite independent of government – unlike England". He also pointed out that "advice, not instruction, will be the output". The Board will issue advice directly to Health Boards and the Scottish Department of Health. He stressed several times that the new board had no responsibility for rationing of health resources.

**Dr Mackay speaking last week**

Referring to the relationship between NICE and HTBS and their advice on a particular therapy, he said that "it was very likely to be the same, but conceivable that there would be a different view."

Dr Mackay said he believed that a chairman had been appointed and would be in post in ten days to two weeks.

## RPSGB museum looks at the healing science

A special millennium exhibition, 'Healing science: pharmacy past, pharmacy future', opens at the Royal Pharmaceutical Society museum on April 3.

The exhibition looks at how the changing view of the human body and its workings has affected the science of healing over the past 1,000 years. It presents how the theory of the humours has shifted, via Paracelsus' theory that the body is a chemical laboratory, to the discovery of bacteria and the human genome mapping project.

In addition to the temporary exhibition, the museum will be hosting other events through the year. Special guided tours will be held on Tuesday and Thursday afternoons in May, June and July starting at 2.30pm. On May 17 an evening lecture given by Professor Roy Porter will look at how caricaturists have lampooned the medical professions. Admission is free.

Further information is available from the museum on 020 7735 9141.

N IRELAND NOTEBOOK

# I bent your ear once, Muriel

The excellent work done by the School of Pharmacy staff at the Queen's University of Belfast (QUB) is often forgotten by the wider pharmacy community. This work has been recognised with top marks in a recent teaching assessment. In our catchment area it was perhaps difficult to justify a school of pharmacy for N Ireland, but the School has grown in size and reputation over recent years and plans to expand.

In the 1970s, when pharmacy became a degree entry profession, the fledgling School of Pharmacy was developed from the lecturers who worked at Belfast Tech. There had been a long association between pharmacy and QUB. In the Department of Pharmacy's early days only 15-20 students per year qualified. In the late 1970s this was up to 30. Numbers have grown steadily, and now about 100 students graduate annually; our School is up with the best.

We have a world class School of Pharmacy in N Ireland of which we should be proud. The staff are highly professional and totally dedicated. One person stands out as exceptional, not in the context of her superb qualifications or her outstanding research record, but for being an excellent teacher, counsellor and friend. She is Muriel Singleton, who has provided pastoral care for most of the current generation of pharmacists. In doing so she has had a huge influence on the standards of pharmacy practice that we have come to expect.

**"She is a professional, dedicated pharmacist, who simply likes people"**

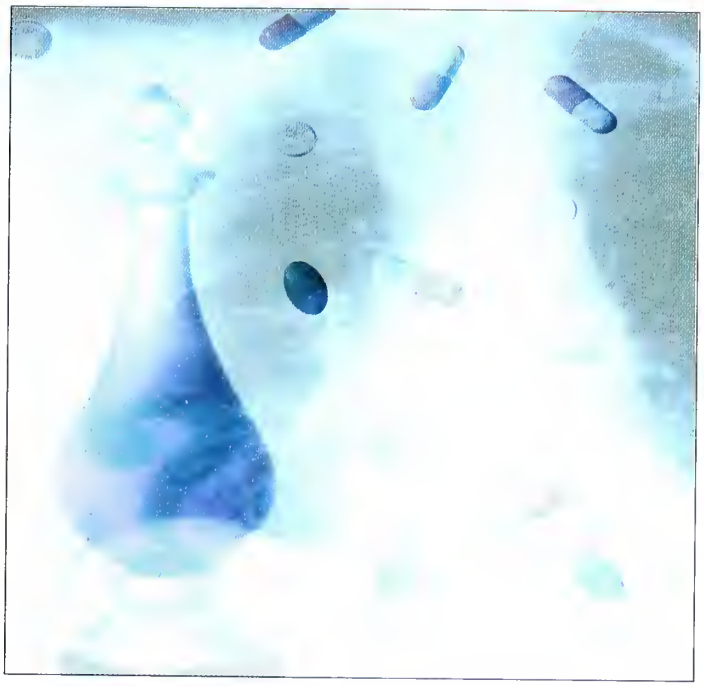
One of pharmacy's unsung heroines, Muriel shows a quiet commitment to her job, and is a professional, dedicated pharmacist who simply likes people. It is this talent with people that makes her such an effective confidant to the troubled student. She acts as a listening ear to all the problems students have, from financial difficulties, to family problems, to social concerns.

She has served on most pharmacy committees and has been the PPET's chairperson. She was awarded a Fellowship of PSNI in the 1980s but this seems little thanks for a lifetime dedicated to her profession and those who practise it. Muriel is still at the School doing what she does best and long may it last.

*Written by a practising Northern Ireland community pharmacist*

# Xrayser

## Topical Reflections



## Smooth but irrelevant talk from Government

From my strategic position at the PSNC dinner I listened intently to the health minister's response to Wally Dove's considered suggestions for a community pharmacy strategy. Mr Dove's speech received well deserved and warm applause, but pharmacy might have been better served if Lord Hunt had never left table 73!

I was bitterly disappointed, and doubt that I will now ever see any Government-backed strategy for community pharmacy introduced in my professional lifetime. However persuasive the logic behind PSNC's bid for a pilot medicines management scheme, I suspect that Tony Blair, as the self-appointed Health Service tzar, now has more important priorities.

Unfortunately community pharmacy has never been a vote winner, and with a general election only 12-18 months away a politician's thoughts must of necessity turn to a second term and votes bought at any cost.

Waiting lists and the problems of acute hospitals will become the priority, and even after the election any initiatives requiring legislation will be subject to the dreaded words 'when parliamentary time permits'.

Meanwhile primary care groups and trusts, walk-in centres and NHS Direct are forging ahead. Over the next few years decisions will be taken at a local level that will shape the long-term future of primary care health services, but owing to government inertia, community pharmacy risks being left on the sidelines.

For once I do not blame PSNC. Wally Dove could not have spelled out more clearly the benefits of involving community pharmacists, but his challenge was effectively ignored by yet another smooth but irrelevant speech from a government health minister.

## One rule for all is the best way

I no longer supply citric acid to anyone I suspect might be using it for the purposes of drug abuse, and have not done so ever since it was confirmed to be an offence under the Misuse of Drugs Act.

However, the demand has not gone away any more than the demand to purchase syringes has, and all this is despite the best endeavours of the local needle and syringe exchange scheme.

In my area there appear to be two distinct groups of drug misusers: those who are willing to use the official channels to obtain clean syringes and those who are not.

A recent announcement from the Royal Pharmaceutical Society indicated that the Law and Ethics Committee would support pharmacists supplying citric acid and water for injection to misusers on harm minimisation programmes. This potentially addresses the problems of the first group, but those in the second group are not mentioned.

However, as a health professional working in the community I feel I have equal responsibility to all, and knowing that products may be used to encourage the misuse of street drugs should not outweigh my primary responsibility for maintaining health.

Using clean drugs, sterile water and sterile syringes must ultimately provide misusers with the safest means of injecting. If they are going to inject in any case, and if the law is to be relaxed, then pharmacists should treat all equally and not be required to distinguish between those on an approved scheme and those who are not.

## Two for the price of one

The supply of Viagra has now settled down into a predictable pattern with a regular flow of both NHS and private prescriptions. However, whereas in the early days most prescriptions were for the 50mg tablets, now almost all are for 100mg.

At first it would appear that Viagra is being restricted to those needy cases which require real help, but appearances can be deceptive. Both NHS and private patients have come to the same conclusion but for different reasons.

The most commonly used dose is still 50mg, but if 100mg tablets are supplied and each tablet is halved then the patient can enjoy the benefits twice, for the price of one.

In the case of private patients this is almost literally true since there is a substantial financial saving to be made by halving the tablet. For the restricted NHS patient, double rations can be obtained for very little increase to the GP's prescribing budget and without breaching the arbitrary limits of 'SLS' regulations!

# Pharmacy service AWARDS 2000

CHEMIST & DRUGGIST

GlaxoWellcome

You know you provide your customers with a good pharmacy service. This is your chance to prove it and walk away with a prize of £1,000 to further improve customer services

The Pharmacy Service Awards seek to recognise and reward the excellent pharmacy service given by individual pharmacies – both independents and multiples – to their customers.

We are looking for examples of pharmacies that make a special effort to meet their customers' healthcare or shopping needs.

Your pharmacy might, for example, place particular emphasis on training and customer care to give an extra dimension to the shopping experience.

You might go out of your way to cater for 'special needs' shoppers. You might specialise in a particular area, such as babycare or sports medicine.

You might offer particular pharmaceutical services, such as regular clinics, or customer-focused health promotion schemes. You may offer an extended delivery service or a medicines management scheme in conjunction with a local surgery.

You may simply display medicines or health information leaflets in a particularly customer friendly way, or cater for mothers with children or the disabled, with wide isles and easy access.

Examples can be given of up to three unique 'selling' propositions or initiatives which contribute to providing your customers with a quality pharmacy service and shopping experience.

For each example you should detail:

- what is the 'USP' or service which your pharmacy offers
- what is the rationale or aim of the service
- how has the service been developed or put into practice
- what it delivers both to the pharmacy and the customer.

## For both multiples and independents

The Awards are open to both independent and multiple pharmacies. In each category the winning entry will take away a prize of £1,000, and the runner-up £500.

Entries should be no longer than 1,500 words, and may be supported by pictures, testimonials from customers, leaflets etc. They should reach this office by May 31.

- Two categories for entry - for independent pharmacists and managers of multiples
- A top prize of £1,000 in each category, and a £500 prize for the runners-up
- The *Chemist & Druggist* Pharmacy Service Awards are supported by Glaxo Wellcome
- Don't delay! Get your entry in now

## Prestige Award

The *C&D* Pharmacy Service Awards are supported by the UK's leading pharmaceutical company, Glaxo Wellcome. Additional entry forms are available from the *C&D* office (phone 01732 377487), or from the Ceuta healthcare sales force.

## The Rules

1. Any pharmacy registered in Great Britain, the Channel Islands, the Isle of Man or Northern Ireland is eligible for entry.
2. Closing date for entries is May 31. The Award winners will be announced in *C&D* on October 7. Individual winners will be notified by July 28. The awards will be presented at a lunch to be held in London on September 21.
3. Entries will be placed in two categories:
   - independents (single pharmacies or groups with no more than four shops) and
   - multiples (groups with more than five branches).
4. The winning entry in each category will receive a prize of £1,000, and the runner-up £500.
5. Entries must be typed or printed, and be accompanied by the entry form (right).
6. The entry and any supporting material (eg photos, practice leaflets etc) may be published within *C&D*.
7. Entries will be judged by a panel of five judges chaired by *C&D* Editor Patrick Grice.

**Please complete the entry form and attach it to the front of your submission. Send your entry, to arrive no later than May 31, to:**

**Pharmacy Service Awards 2000, *C&D*, Miller Freeman House, Sovereign Way, Tonbridge, Kent TN9 1RW.**

Pharmacy service AWARDS 2000

CHEMIST & DRUGGIST

GlaxoWellcome

Name of person submitting entry.....

Position.....

Pharmacy address.....

.....

.....

.....

.....Post code.....

Phone number.....

Contact name (if different from above).....

.....

Company name (if different from above).....

.....

Category (please tick): Multiple ❑ Independent ❑

## PM calls for end to professional demarcation

The Prime Minister has called for an end to "outdated demarcations between professionals" in the NHS.

Tony Blair set out five challenges for the health service in a statement to the House of Commons last Wednesday. One of these was "for the professions to strip out unnecessary demarcations, introduce more flexible training and working practices and ensure that doctors do not use time dealing with patients who could be treated safely by other healthcare staff".

Over the next few months both the PM and the health secretary Alan Milburn will meet with those responsible for healthcare in every part of the country, as well as consulting the leaders of the professions and organisations.

In addition, for each of the five challenge areas, "there will be a dedicated unit to examine the problems and come up with solutions". These will be led by a health minister and a "key leader from the health service". Vice chairman of the All-Party Pharmacy Group Lord Newton has been appointed to the Patient Care (Speed of Access) modernisation action team reporting to health minister Lord Hunt.

### In the driving seat...

Health secretary Alan Milburn repeated that doctors and nurses will be deciding how the money is spent in the modernised NHS.

The new resources will help the NHS to run balanced budgets year after year, he told the Commons. "They will fund new drugs, improve services for cancer and coronary care, and help to speed up treatment for patients. There will be resources to help primary care groups develop their services and resources to develop intermediate care services.

"I shall get the money out there. It will go to health authorities and then on to PCGs. The PCGs will decide. Local doctors and nurses are in the driving seat – not bureaucrats sitting in HAs – and it will be up to them to decide where the money goes."

### RPSGB writes to Blair

Royal Pharmaceutical Society president Christine Glover has written to Mr Blair outlining pharmacists' extensive skills and expertise, emphasising support for the modernisation programme.

"The NHS is at a crossroads in service delivery and patient care," said Mrs Glover. "Decisions made now will affect the future of patients, professionals working in the NHS and government spending. It is crucial that we seize this opportunity to secure a co-operative role for pharmacists..."

# Pharmaceutical Care Centre opens at RGU

A £400,000 Pharmaceutical Care Centre has opened at the Robert Gordon University in Aberdeen.

The centre incorporates a mock GP surgery, hospital location and drug information centre. It is stocked with 10,000 sets of primary and secondary care case notes and in addition to pharmacy lectures, GPs are on hand to demonstrate basic clinical examination techniques. Real patients are used in teaching.

Professor Clare Mackie, who is head of the School, said: "The Centre enables us to simulate real-life clinical situations, which our students are likely to be presented with after they qualify, enabling them to fast-track their learning in a protected environment. It allows them to fine-tune their knowledge and skills and match this with what will be required of them in their professional role, before entering the clinical environment. This will not only enhance the students' learning experience but also protect patients."

Last week's opening followed the RGU School of Pharmacy's designation as the World Health Organization's Collaborating Centre for Pharmaceutical Care and Curriculum development.

**Nicol Stephen MSP speaking to Kelly Mitchell, a final year student from Kirkcaldy**

## Quit smoking and win £5k


Smokers who quit have a chance to win £5,000 and supporters £500, as part of the fourth international Quit & Win competition.

The No Smoking Day organisation is promoting the May event, supported by Pharmacia & Upjohn, Glaxo Wellcome, Bedfont Scientific and the NHS. Quitters will have to abstain from smoking or using tobacco products for a four-week period from May 2-29 in time for World No Smoking Day on May 31. There will be 12 UK regional cash prizes of £1,000 for quitters and £100 for their supporters. The UK final cash prize is £5,000 for the quitter and £500 for the supporter, and one UK winner will go forward to further international prize draws worth up to $10,000.

Entry is open to people aged 18 or over who have been daily smokers for at least one year and have registered with the competition by May 2. Entrants must pledge to be completely smoke-free during May and must have a witness who can verify that they have definitely given up smoking.

More information is available on the web at *www.no-smoking-day.org.uk* For entry leaflets call: 0800 244 8387.

# Pharmacists rated highly for information

Doctors and health authority executives rate pharmacists highly as a source of information.

When asked to rank eight information sources in order of preference, doctors placed pharmacists second only to the pharmaceutical industry, while health managers put pharmacists third after the NHSnet and the National Electronic Library for Health. The managers put industry sources at the bottom of the list.

The survey, carried out for the Association of the British Pharmaceutical Industry, looked at attitudes to the Government's proposals to encourage patients to become experts in looking after their own health. Both doctors and health managers thought that if patients were better informed, more treatments would become available, although NHS costs would rise and there would be more litigation.

While 83 per cent of managers favoured the 'expert patient', only 21 per cent of doctors did so. Half the doctors thought rationing would increase, 58 per cent thought they would have more work to do, and only 12 per cent thought the doctor-patient relationship would improve.

The managers were much more likely to say there would be better health outcomes (93 per cent) and an overall improvement in NHS healthcare (95 per cent), although 79 per cent thought rationing would increase. Only 24 per cent of doctors thought there would be better health outcomes and 14 per cent an overall improvement in healthcare.

The results of the survey are published in a booklet, 'The expert patient', in which journalist John Illman argues that everyone – not just people with chronic illness – needs guidance on being a patient and getting the most out of a doctor's consultation. Many people deny they are ill, often with fatal consequences. Some are afraid to ask questions or forget what they are told.

Patients who do not develop information and communication skills could become the new underclass in a two-tier health system. In a 'Patient's code', the author recommends that patients take written notes of the consultation or, with the doctor's approval, use a tape recorder if the information given is likely to be complex.

"Patients need a good bedside manner to get the best out of the doctor," he says.

The booklet (£2) is available from the ABPI publication department, 12 Whitehall, London SW1A 2DY.

## HAs hold back £93m

A failure by health authorities to pass on the £93 million allocated for primary care groups to meet higher bills for generic drugs lies behind the Health Secretary's tough talk last week about providing resources for the 'front line first'.

Alan Milburn was said by aides to be 'furious' that the money allocated in December to meet the sudden surge in generic drug prices was not passed down to the primary care groups who needed it.

He told MPs he was allocating £600m for general improvements in health across the board to all health authorities from the extra resources made available in the Budget with a further £60m in a bonus fund available to PCGs who meet the Government's targets for reducing waiting lists, ending bed blocking, or tackling winter pressures.

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(an independent pharmacist, Beith, Scotland)

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## IN BRIEF

**Bactroban Cream**

Bactraban (mupiracin calcium) is naw available in a nan-greasy cream presentation (15g tube £4.71 basic NHS) ta imprave patient campliance. It is indicated far the tapical treatment af secandarily infected traumatic lesions such as lacerations and sutured wounds.

SmithKline Beecham Pharmaceuticals. Tel: 01707 325111.

**Zocor 80mg tablet**

MSD has intraduced an 80mg Zacar (simvastatin) tablet which it says offers "significant additianal lipid-lowering efficacy compared to commonly prescribed doses of statins". It casts the same as the 20mg and 40mg tablets (28, £33.40).

Merck Sharpe & Dahme Ltd.
Tel: 01992 467272.

**New urine analysis strips**

Bayer is intraducing twa new urine analysis strips. Clinitek Micraalbumin is an 'instrument read only' test strip far use in manitaring kidney functian in diabetes and hypertensian patient management. Microalbustix is a 'visual read only' strip providing the same infarmatian. Bath retail in battles af 25 strips at £42.19.

Bayer Diagnostics Division.
Tel: 01635 563000.

**AstraZeneca discontinuations**

AstraZeneca is discontinuing a number of products and packs from June. Discantinued praducts include: Fulcin tablets and suspension, Sarbitrate and Sarbichew, Xylocaine vials and gels, Xylapract suppas and Vivalan. Credit will nat be pravided for returned gaads. Due ta manufacturing prablems na new arders can be accepted for Citanest 0.5% SDV, Citanest 1% and Citanest 2% (50ml x 5 vials). Far full details of products affected cantact:

AstraZeneca Custamer Services.
Tel: 01536 424254.

**Xatral XL 10mg**

Xatral XL 10mg tablets, containing 10mg alfuzasin in a pralanged release formula, are being added to the range far ance daily therapy far the symptomatic relief af benign prastatic hypertraphy (packs of 10 ar 30, £7.93 and £23.80 basic NHS).

Sanafi-Synthélaba Custamer Services. Freephone 0800 854430.

# Combination therapy for migraine sufferers

Elan Pharma is offering migraine suffers a new treatment option with the launch of Migramax, a combination of an analgesic and an anti-emetic.

Migramax, which contains acetylsalicylate and metoclopramide, is indicated for the treatment of migraine-associated symptoms such as headache, nausea and vomiting. Formulated as a powder, which must be dissolved completely in water before taking, each sachet of Migramax contains the equivalent of 900mg of acetylsalicylic acid and 10mg of metoclopramide.

The recommended dose for adults aged 20 and over is one sachet, to be taken at the first warning of a migraine attack. A second sachet may be taken two hours later if the symptoms have not resolved. Patients should be advised not to exceed three sachets in a 24-hour period.

Migramax is not recommended for patients under 20 because of the risk of dystonic reactions in young adults and children. It should not be given to patients with active, chronic or recurrent gastric or duodenal ulcers, a history of hypersensitivity to salicylates, or those with congenital or acquired bleeding disorders. Its use is also contra-indicated in the third trimester of pregnancy and it should be avoided in patients with asthma or rhinitis who may be at risk of developing sensitivity reactions. Care should be taken in patients using an intra-uterine device and patients who have a high alcohol intake.

The most common side effects occurring with therapeutic doses of salicylates are gastrointestinal disturbances. Although a low incidence of side effects has been associated with metoclopramide, they do include drowsiness and lethargy, which may affect the patient's ability to drive or operate machinery.

Migramax is available in pack sizes of six sachets and 20 sachets with basic NHS prices of £7 and £23.33 respectively.

Elan Pharma Ltd.
Tel: 01462 707220.

## MEDICAL MATTERS

# US marketing of cisapride to cease in mid-July

Cisapride (Prepulsid), the prokinetic agent used to treat gastroesophageal reflux disease, will no longer be marketed in the US from July 14.

The licence holder, Janssen, will only make the product available on a limited-access basis to people who meet specific clinical eligibility criteria, which are being drawn up with the Food and Drug Administration.

The decision has been prompted by increasing restrictions on the use of cisapride due to links with cardiac arrhythmia. As of December 31, 1999, cisapride had been associated with 341 reports of heart rhythm abnormalities including 80 deaths. However, most of these adverse events occurred in patients who were taking other medication or were suffering from underlying conditions known to increase the risk of cardiac arrhythmia associated with cisapride.

In an effort to ensure that the drug was being prescribed safely, labelling changes were introduced over several years. Despite this, Janssen says, some inappropriate use has continued and it believes the best way to deal with the problem is to limit access.

In the UK, a spokesman for Janssen-Cilag said there would be no immediate changes, although the company is updating the Medicines Control Agency on the situation and there may be changes over the next few months.

The company stresses that there are a number of differences in the use of cisapride between the two countries. The maximum allowable dose in the US is 80mg - twice that of the UK - and the indications for use also differ.

In the US the drug is only approved for severe night-time heartburn in adults with gastroesophageal reflux disease, whereas in the UK it is licensed for maintenance therapy of reflux oesophagitis, non-ulcer dyspepsia and symptomatic relief of delayed gastric emptying as well as symptoms of gastroesophageal reflux.

# Laboratory standard diabetes test for primary care

A new test for diabetes takes the laboratory standard into the community.

The new test, known as Glycosal, has been developed by UK diagnostic firm Provalis. It measures 'HbA 1c', or glycated haemoglobin, recognised as the most useful and important way of testing the status of patients with diabetes. Up until now this test could only be performed in a laboratory.

The Glycosal test takes only four minutes and can be carried out using a bespoke device by a GP or practice nurse during a consultation with the patient. The HbA 1c test can give a clear picture of the patients' glucose levels over the previous two to three months, indicating how well controlled the patients' diabetes has been.

Previously a blood sample would have to be taken at one visit and sent to a local hospital for testing. The patient's treatment would then be assessed at their next visit using a laboratory result already two weeks or more out of date.

At present the product is not being promoted to pharmacists, but a pilot study is being undertaken and Provalis expects pharmacists to be playing a larger role in this type of testing.

Provalis Diagnostics.
Tel: 01244 288781.

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**We'll still be sponsoring GMTV's pollen forecast. But this year we'll also be sponsoring the National Pollen Research Unit's web site.**

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ALLERGY cetirizine

## NOTHING HITS HAYFEVER HARDER

**ZIRTEK ALLERGY**
**PRESENTATIONS:** White, oblong, scored, film-coated tablet engraved Y/Y containing 10mg cetirizine hydrochloride.
**USES:** Treatment of seasonal and perennial rhinitis and chronic idiopathic urticaria.
**DOSAGE AND ADMINISTRATION:** Adults and children aged 6 years and over: 10 mg once daily. In renal insufficiency halve the dose to 5 mg (½ tablet) daily.
**CONTRAINDICATIONS:** Hypersensitivity to constituents. Avoid use in pregnancy and lactation.
**PRECAUTIONS:** Do not exceed recommended dose, particularly if driving or operating machinery.
**DRUG INTERACTIONS:** To date there are no known interactions with other drugs. As with other antihistamines avoid excessive alcohol consumption.
**SIDE EFFECTS:** Mild and transient drowsiness, headache, dizziness, agitation, dry mouth and gastrointestinal discomfort have been reported.
**PACKING, PRICE:** Pack of 7 tablets = £4.25 Retail.
**LEGAL CATEGORY:** P
**PRODUCT LICENCE NUMBER:** Tablets 5221/0001.
**MARKETED BY:** UCB Pharma Limited, Watford, Herts, WD1 8UH.
**For further information please contact:** UCB Pharma Limited, UCB House, 3 George Street, Watford, Herts, WD1 8UH.
Telephone (01923) 211811. Facsimile (01923) 229002.
Date of preparation: March 2000
UCB-Z-00-03

ucb Pharma

# Counterpoints

## Benadryl offers topical relief to allergy sufferers


Warner-Lambert is expanding the OTC allergy treatment market in pharmacies by launching a new P licensed topical range for allergy sufferers under its Benadryl brand.

Benadryl Allergy Relief Lotion and Cream are formulated to quickly relieve the irritation of skin allergies. The products also relieve prickly heat and sunburn.

The choice of cream and lotion offers versatile treatment options – the viscous lotion is suitable for a large area of sunburn, while the thicker cream is ideal for treating bites and smaller areas of skin.

The active ingredients in both products are diphenhydramine hydrochloride 1 per cent, camphor 0.1 per cent and zinc oxide 8 per cent.

Research shows that while systemic treatment remains the preferred method for most allergy sufferers (in particular for hay fever and allergic rhinitis symptoms), many sufferers of skin allergies and other skin irritants prefer a topical formulation.

Warner-Lambert predicts that the launch will encourage existing Benadryl users to extend their purchasing habits into the topical sector.

Retail price for both products is £3.55.

Warner-Lambert Consumer Healthcare.
Tel: 023 8064 1400.

## Blister packs for herbal remedies

Herbal Concepts is launching eight of its herbal remedies in blister/carton packaging.

The new packs will be introduced this month for Backache Relief, Daily Tension and Strain Relief, Period Pain Relief, Wind and Dyspepsia Relief, Menopause Relief, Laxative Tablets and Daily Overwork and Mental Fatigue Relief.

The blister packs are designed for easy shelf display and feature clear, simple graphics. The products will also still be available in pots.

Indigestion Relief will be available in blister packs from the summer.

Retail prices range from £2.99 to £3.99.

Herbal Concepts Ltd.
Tel: 01296 689045.

## Raising awareness of women's health

Whitehall Laboratories' Caltrate Plus calcium supplement is sponsoring a new 'Women's Health' booklet from the National Federation of Women's Institutes.


The initiative aims to help raise widespread national awareness of the importance of maintaining healthy bones and preventing osteoporosis among women aged 35 and over.

The booklet will advise on many aspects of women's health in later life including bone health, HRT, lifestyle, exercise, mental health, cancer, heart disease and overall wellbeing.

The booklet launch will take place at an event organised by the NFWI and Research into Ageing on April 5.

Whitehall Laboratories Ltd.
Tel: 01628 669011.

## Newborn arrival from Mam

**Mam is introducing a new soother collection for newborn babies.**

**Mini Ulti Clear has the same design features as the existing Mam newborn soother, but comes with a crystal clear shield and pastel knob with four design variations.**

**The shield is concave and contoured with safely rounded edges for maximum comfort. A system of large ventilation holes and dimple patterns reduces the risk of skin irritation by trapped saliva.**

**The extra soft orthodontic teat is smaller and shorter than standard teats. Designed to hang-sell, clear plastic blister packs contain two soothers.**

**Retail price is £3.49.**

**Mam (UK) Ltd.**
**Tel: 0121 326 6992.**

## Gimme five ... from Power

Power Health is launching five new products in a tablet format.

The Power Health range now includes Mexican Wild Yam 500mg tablets (rsp £2.50, 30), Soya Isoflavones with Kudzu Root & Red Clover tablets (rsp £5.25, 30) and Calcium Pangamate 50mg tablets (£5.99, 50).

The Power Herbs range is being extended with St John's Wort 334mg tablets and 500mg tablets.

Power Health Products Ltd.
Tel: 01759 302734.

## Magnetic Thera: P is an opportunity for pharmacy

The HoMedics Thera: P range of magnetic products is being launched in the UK following successful launches in the US and Ireland.

The Thera: P range is based on the principles of magnetic wave therapy, a non-invasive treatment using static magnets. It is thought to work by increasing blood flow and oxygen to the area affected by pain. Increasing the blood flow can produce higher levels of anti-inflammatory white blood cells and oxygen-rich red blood cells, which can help promote pain relief and general wellbeing across a number of conditions such as sprains, backache and headache.

Another possible mode of action is the generation of low levels of electrical current, as ions within blood compounds respond to the magnetic field. These microscopic currents may have an effect on neurotransmitters, helping to divert or block electrical signals.

The range of 25 products includes magna dot plasters which can be applied to any part of the body, cushioned or massaging insoles and bedding material such as a pillow liner. Retail prices range from £7.99 for the Magna Dots to £199.99 for a king-size Mattress Topper. Further product information is available from the company or you can visit the web site at *www.homedicsuk.com*.

A compact display stand holding nine products and a counter display unit for the bracelets are available.

HoMedics (UK) Ltd.
Tel: 0161 798 5885.

# Treatments at your fingertips

Original Additions is launching a new collection of nail treatment products in its Elegant Touch range on April 25.

Elegant Touch Perfect 10 comprises six nail treatment products.

Nail 'Food' is a concentrated blend of vitamins, minerals, strengtheners and moisturisers designed to encourage the growth of stronger new nails. It contains root ginger to help stimulate heat and increase circulation through the matrix.

Bright, White Nails is a clear gel that contains cleansing agents to brighten and whiten dull, stained and discoloured nails. It is suitable for gardening, smoking and nail polish stains.

Inner Strength is applied over the nail and under the tip to improve the structure of the nail. It helps build strength and flexibility, as well as reducing flaking, peeling and splitting.

5+5=10 Hard Nails adds a clear coat to protect and harden nails. It is enriched with vitamin E, panthenol, coconut and jojoba oils to encourage strength and flexibility.

Cuticle Perfect is a double action cuticle remover and cuticle moisturiser. It contains gentle pineapple and passion fruit AHAs to encourage the removal of dead skin.

Stop Biting has a discreet matt finish, doesn't wash off and has a particularly revolting taste to keep nails away from the mouth. It is fortified with calcium and vitamin E.

Prices range from £4.45 to £4.95.

**Original Additions (Beauty Products) Ltd.**
**Tel: 020 8573 9907.**

# The Power to help combat cellulite

Power Health is launching a new anti-cellulite lotion and anti-cellulite cream under its Slim-nite brand.

Both the cream and lotion are designed to help combat cellulite and are claimed to have diuretic and astringent properties.

The products are formulated to increase the strength and tone of the veins and to help support the circulatory system.

Active ingredients include L-Ornithine, L-Arginine, L-Carnitine, bladderwrack extract, oak bark extract, ivy extract and horsechestnut extract.

Retail prices are £7.99 for 50g cream and £9.99 for 250ml lotion.

**Power Health Products Ltd.**
**Tel: 01759 302734.**

# Rivage arrives from the Dead Sea

Rivage, a new range of skincare and bodycare products based on natural Dead Sea minerals, has been launched in the UK.

The 66 products in the Rivage range contain the highest concentration of natural Dead Sea minerals on the market today. The main ingredient is carnallite, a crystal found in the Dead Sea consisting of calcium 7, potassium, sodium and magnesium chloride. Plant and herbal extracts are added to the Dead Sea minerals to maximise their efficacy. The products are said to offer solutions in anti-ageing, cellulite control, skin purification, and improved circulation, as well as total skincare for all skin types.

Dead Sea minerals have been successfully used in the treatment of eczema, acne, psoriasis and dermatitis, and the healing effects of tar, bromine magnesium and zinc contribute to this.

The extensive product range includes facial exfoliant, make-up remover, mineral soaps, hand cream, hair spray and mud masks for the body and face. Retail prices range from £10 to £40. All Rivage products are hypo-allergenic and not tested on animals.

**Lingcroft Rivage. Ltd.**
**Tel: 01274 864863.**

## Lip reading

Collection 2000 is launching two new lipstick ranges.

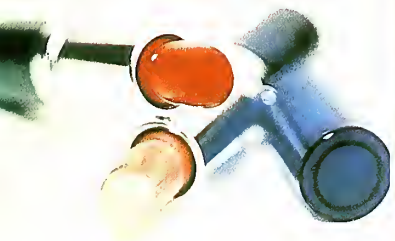
True Moisture Lipstick has a conditioning formulation that contains pro vitamin B5, vitamin E, mango kernel oil and UVA/UVB sunscreens.

Available in 20 shades, the lipstick comes in a midnight blue case with a colour-coded base label. Retail price is £1.99.

True Glossy Lipstick is a glossy, high shine lipstick containing vitamin E and UVA/UVB sunscreens.

The lipstick is presented in a translucent bright blue case and comes in ten shades. Retail price is £1.89.

**Collection 2000 Ltd.**
**Tel: 01695 50078.**



## New guide helps people buy health supplements

The Health Supplements Service (HSIS) is launching a free guide to help consumers make a more informed decision when purchasing health supplements.

The guide advises the public to be wary of any 'miracle' cure or exaggerated claims on the labels and to use a recognised retailer such as a pharmacy.

It also recommends choosing a recognisable brand that can be trusted to ensure the highest level of quality control.

For details about specific health supplements, consumers can visit the HSIS web site *www.hsis.org*. This web site provides information about the measurements and RDAs for vitamins.

Consumers can receive a copy of the guide by sending an A5 stamped addressed envelope to HSIS, Bury House, 126-128 Cromwell Road, London SW7 4ET.

**HSIS.**
**Tel: 020 7370 2233.**

# Fresh new scent joins Coty classic

Coty is launching a new fragrance aimed at 35-50-year-old women.

Toujours L'Aimant is the younger 'sister' of the romantic floral L'Aimant fragrance which was created in 1927, and it is aimed to appeal to the over 45s.

Coty research has identified consumer demand for a more youthful, feminine and contemporary fragrance that retains the same L'Aimant image and rich heritage.

Toujours L'Aimant is a fruity floral fragrance with fresh top notes that combine citrus with exotic fruits.

The middle notes are romantic florals of jasmine, rose, freesia and lily of the valley, and the base is formed by warm amber, sandalwood, a hint of musk and oak moss.

The range comprises EDT natural spray in two sizes (rsp £9.95 for 30 ml, £6.95 for 15ml) and a deo body spray (rsp £2.29 for 75ml).

The fragrance is presented in a spiralling hexagonal bottle with key design signatures – packaged in a modern lilac, pink and white carton.

The launch will be supported by a £750,000 package incorporating women's press advertising, scent strips and sampling.

A range of PoS material echoes the key design signatures and includes hexagonal merchandisers, display cubes and tissue, a showcard and a poster of the 'love and be loved' print advertisement.

**Coty (UK) Ltd.**
**Tel: 020 8971 1300.**

## Fructis adds more shine to summer hair

Laboratoires Garnier will extend its Fructis haircare range with three new products in June.

Fructis Ultra-Detangling Conditioner for Long Hair is designed to add strength and shine to medium to long hair without over conditioning.

It includes detangling agents to make styling easier without leaving the hair feeling weighed down, which can often result from too much conditioning.

Fructis 2 in 1 Anti Dandruff Shampoo and Conditioner is claimed to eliminate dandruff after seven days. It is formulated to help prevent dandruff recurring as well as to remove itchiness and irritation.

The 2 in 1 product has a pleasant fruity fragrance and contains the active ingredient octopirox, which acts directly on the scalp.

Fructis Greasy Roots, Dry Ends Fortifying Shampoo has been developed for combination hair. It is formulated to leave the scalp feeling clean and the roots deeply nourished.

Fructis products contain an active fruit concentrate, which includes fructose, glucose, fruit acids and vitamins B3 and B6. All the products will retail at £2.19 for 200ml.

A new exercise workout to help create shiny, healthy hair, Fructis Hairobics, has been devised. The routine will be promoted in health clubs and leisure centres from June.

**Laboratoires Garnier.**
**Tel: 020 8762 4010.**

## IN BRIEF

### Powders for darker skins

Iredale Mineral Cosmetics is introducing its Purepressed mineral foundation powders in eight new shades for darker skins. The new shades range from deep gold to deep mahogany for Black, Asian, Hispanic and European skins. The powders are designed to provide a foundation powder, concealer and sunscreen oil in one. Retail price is £39.

Iredale Minerol Cosmetics Ltd.
Tel: 0800 328 2467.

### Irish distributor for Periproducts

David Mayrs, the Irish distribution and sales company, has been appointed to launch the Periproducts range of oral hygiene products in Eire and Northern Irelond. The range includes the Retardex oral rinse and spray and stain-removing Retardent toothpaste.

David Mayrs Ltd.
Tel: 00 353 (0)1 830 1555.

### Breaking down taboos

Warner-Lambert is supporting its Anusol hoemorrhoid brand in independent pharmacies with category merchandising units to help raise customer oworeness. New educational and promotional initiatives running throughout this year are designed to help break down the stigma and taboos associated with piles.

Warner-Lombert Consumer Healthcare.
Tel: 023 8064 1400.

### Help for IBS sufferers

Chefaro Proprietaries is launching two Equilon information services for IBS sufferers. A new web site *www.equilon.co.uk* has been created, in conjunction with the Central Middlesex Hospital IBS Research Appeal, which offers general education and advice on IBS. A new information service, 'In touch with IBS', comprises a series of free fact sheets on the different problems and symptoms associated with IBS, and offers self help advice.

Chefaro Proprietaries Ltd.
Tel: 01480 421800.

## ON TV NEXT WEEK

**Clearblue Home Pregnancy Test:** G, A, W

**Fybogel:** G, Y

**Gillette Mach3 razor:** All areas

**Oxy:** All areas except U, CTV, GMTV

**Panadol:** All areas except U, CTV, GMTV

**Propain:** B, G, M, LWT, TT

**Radox Showerfresh:** GMTV, ITV, C5, Sat

**A** Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

# PHARMACY update

# Broken hearts

Heart failure is predominantly a disease of the elderly, but the increasing ageing population means it is becoming more common. It is still a poorly treated condition and the target of a National Service Framework. Mike Holland gives an overview of the disease

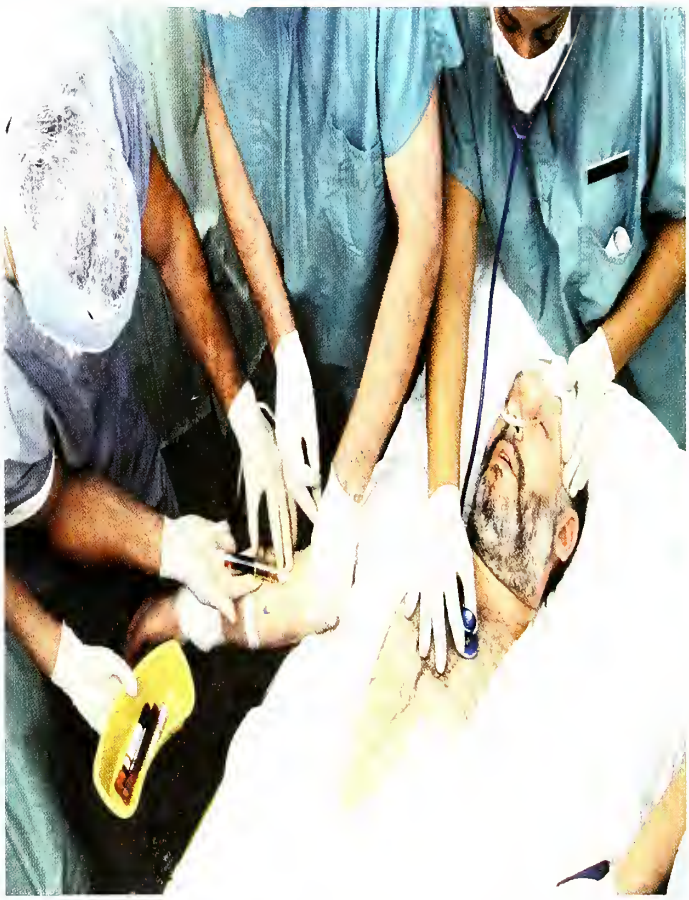


THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1158), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* MAY 6, PROVIDES ONE HOUR'S CONTINUING EDUCATION

## OBJECTIVES

- To understand the epidemiology and prognosis for patients with heart failure
- To recognise the importance of proper health and lifestyle advice in its management
- To be aware of the pharmacist's role in community based shared care programmes
- To understand the implications of the forthcoming NSF on coronary heart disease



Heart failure is one of the oldest diseases known to man. As 'dropsy' it was well known to the ancient Greeks who treated it with white wine. It was not until 1795 that William Withering, physician to the General Hospital at Birmingham, wrote about the value of treating the condition with digitalis.

Diuretics joined digitalis in the 1930s, yet despite newer drugs in recent decades, heart failure remains a poorly treated condition. It has now been targeted as an area for health improvement in a forthcoming National Service Framework for Coronary Heart Disease.

The NSF should ensure that people with suspected heart failure are offered the proper investigations to confirm or refute the diognosis. Where heart failure is confirmed, its cause should be identified and patients should be offered the treatments most likely to relieve symptoms, and reduce the risk of death.

Heart failure is a progressive condition that usually develops slowly over several years. It does not mean the heart has given up, rather that it is not working as efficiently as it should. This inability to pump sufficient blood around the body to meet the needs of the circulatory system results in the signs and symptoms of physical deterioration associated with heart failure:

- **Exercise intolerance**. Patients will often tire easily, in part because of the reduced blood flow to muscles as they exercise
- **Breathlessness**. There may be a productive cough due to congestion in the lungs and shortness of breath, which often leads to the misdiagnosis of respiratory infection
- **Swelling**. There may be fluid retention and venous engorgement, particularly affecting the ankles, legs and abdomen.

## Epidemiology and pathophysiology

Heart failure is predominantly a disease of the elderly and as such is becoming relatively more common as people live longer.

Estimates of the number of people with heart failure vary between three and 20 per 1,000 of the population, rising to between 30 and 130 per 1,000 among those aged 65 years or older. Annual incidence data range from one to five per 1,000, rising as high as 40 cases per 1,000 among those aged 75 years or older.

Heart failure is often the result of underlying disease to the heart muscle, resulting either from systolic dysfunction (where the pumping efficiency of the heart is compromised) or diastolic dysfunction (where the ability of the heart muscle to relax and fill between beats is compromised), or from both.

In the UK, most cases are due to coronary heart disease and about a third result from hypertensive heart disease. Other causes are valvular disease, excessive alcohol intake, infection and pregnancy, as well as a genetically determined dilated cardiomyopathy. Data on the incidence and prevalence of heart failure vary widely, although there is general agreement that both are rising, despite the overall decline in mortality from CHD. This, together with the prevalence of hypertension in the elderly and an increasing life expectancy, have all combined to make heart failure one of the most common malignant diseases of developed nations. Unsurprisingly, heart failure accounts for a considerable amount of NHS expenditure. It is responsible for more than 1 per cent of the NHS budget. Hospitalisation accounts for about two-thirds of this.

*Continued on PII →*

Continued from PI

## Diagnosis

Appropriate diagnosis, and treatment can improve the quality of life and help reduce morbidity and mortality from heart failure, although many patients are neither adequately diagnosed or treated.

Evidence also suggests that many of those who are treated do not actually have heart failure. This may be because many of the signs and symptoms of heart failure (such as dyspnoea, orthopnoea and oedema) are non-specific and may often be mild.

Heart failure is graded as mild, moderate or severe, depending on whether symptoms appear during exercise, minimal exertion or at rest. Ideally, the diagnosis should be based on the history and presence of symptoms backed up by objective evidence of cardiac dysfunction. Investigation of heart failure should aim to:

- confirm or refute the presence of the condition
- identify its aetiology
- exclude other conditions that can exacerbate myocardial ischaemia,
- assess left ventricular function,
- estimate cardiac risk and prognosis.

Measures of cardiac function are provided by:

- electrocardiography – to detect signs of ischaemia or previous myocardial infarction
- imaging techniques – to reveal the extent of the disease
- echocardiography – which uses sound waves to build up an image of the heart and valves, and allows measurement of the pumping efficiency of the heart.

## Prognosis is bleak

The prognosis for patients with heart failure is bleak, despite the advent of new treatments. Survival rates are often worse than for breast and prostate cancer.

Annual mortality for patients with heart failure ranges from 10 per cent to more than 50 per cent depending on severity. It is thought that each year there are some 60,000 deaths due to heart failure associated with CHD, and patients are at high risk of sudden death.

Treatment with ACE inhibitors and beta-blockers has, however, had a beneficial effect on both mortality and morbidity. Nevertheless, the outlook for many patients will depend on their age, severity of heart failure and overall health.

As the disease progresses, patients often lose the ability to perform even modest degrees of activity. They have a poorer quality of life than people with most other common medical conditions. Psychosocial function is also impaired, with more than a third of patients experiencing severe and prolonged episodes of depression.

## Hospitalisation

Although heart failure, which can be either acute or chronic, is often managed in primary care, recent years have seen a steady, year-on-year rise in hospitalisations for the condition.

It now accounts for about 5 per cent of all hospital admissions, and for a sizeable number of re-admissions – rates for heart failure are among the highest for any common condition, and have been estimated to be as high as 50 per cent over three months. However, about half of these may be preventable. Re-admission is commonly due to:

- uncontrolled symptoms
- non-compliance with medication and dietary measures
- over-consumption of alcohol
- intercurrent infection
- failed social support
- psychological problems.

Many patients with heart failure, as well as their families, benefit from social support and the provision of relevant information about their condition. Such interventions have been shown to help reduce hospital re-admission and include:

- education of patients and carers about heart failure, its monitoring and self-management
- practical dietary advice
- advice on physical activity.

## The NYHA class system for rating heart failure

The New York Heart Association rating scale is a tool for grading the severity, prognosis and response to treatment in heart failure.

| Class | Definition |
|---|---|
| Class I | No symptoms or limitation of everyday physical activities |
| Class II | Slight limitation of physical activity due to symptoms during ordinary physical activity, for example when climbing stairs |
| Class III | Marked limitation of everyday physical activities due to symptoms such as breathlessness from even minimal exertion |
| Class IV | Inability to perform any activity without discomfort, or [experiencing] symptoms at rest; discomfort is increased with any physical activity |

## Management of heart failure

The morbidity associated with managing heart failure results in recurrent visits to the GP and hospitalisation. Ideally, appropriate treatment of the underlying disorders that predispose towards heart failure would prevent or delay its onset.

These include treatment for high blood pressure and diabetes, and rapid thrombolysis after an acute myocardial infarction. However, once heart failure itself has set in, the aims of treatment should be:

- to control symptoms
- to improve quality of life
- to slow disease progression.

### Non-pharmacological management

All patients with heart failure should be given lifestyle advice:

- **Diet** – being overweight can put excessive strain on the heart, particularly during exercise. A good diet should be encouraged with avoidance of excessive alcohol (which can damage the heart muscle) and salt (which is associated with fluid retention)
- **Exercise** – regular exercise is associated with significant benefits for patients with heart failure
- **Smoking** – smoking worsens heart failure by causing vasoconstriction.

In addition, patients should be given advice and treatment to control their blood pressure and (if diabetic) blood glucose. They should also be offered annual vaccination against influenza, and a one-off vaccination against pneumococcus.

### Pharmacological management

- **ACE inhibitors** are the first-line agent in the management of heart failure. In addition to their beneficial antihypertensive effects, they have been shown to prevent the onset of symptoms in asymptomatic patients and to reduce hospitalisation rates and mortality rates in patients with overt heart failure.

In up to 20 per cent of patients, however, ACE inhibitors are poorly tolerated due to the development of a cough that accompanies the release of bradykinin. In such cases, an angiotensin II receptor antagonist may be used, although initial enthusiasm for their use in heart failure has not been borne out in trials. None are currently licensed for this indication.

Alternatively, nitrates and hydralazine may be substituted.

- **Diuretics** are used to counteract fluid overload in heart failure as well as to treat high blood pressure. Although they alleviate the symptoms of heart failure, they have not been shown to be

Continued on PIV →

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*Continued from PII*

associated with a survival benefit.

- **Digoxin** is the oldest known treatment for heart failure and is still used to relieve symptoms for worsening heart failure, although there is no mortality benefit. It is most likely to be used in patients with associated atrial fibrillation.
- **Beta-blockers** have previously been contra-indicated in heart failure as they reduce the heart rate and force of contraction. There is now a substantial body of evidence to suggest that some beta-blockers have an additional morbidity and mortality benefit over ACE-inhibitors and diuretics in patients with heart failure.

Carvedilol, for example, is a non-selective beta-blocker with alpha-blocking vasodilator properties that has been shown to reduce mortality and hospital admission rates when added to a regimen of ACE-inhibitors and diuretics.

Similarly, studies involving the beta-1 selective blockers bisoprolol and metoprolol have also shown an additional survival benefit when added to a regimen of ACE-inhibitors, diuretics and digoxin.

However, initiating treatment with beta-blockers is complex and time-consuming – the standard practice is to start low and go slow – so they should only be initiated in secondary care or in a specialised heart failure clinic.

## Shared care

Most specialists agree that the best way to manage heart failure is in the community, and that it should be based on the principles of shared care (in a similar manner to how diabetes care is organised).

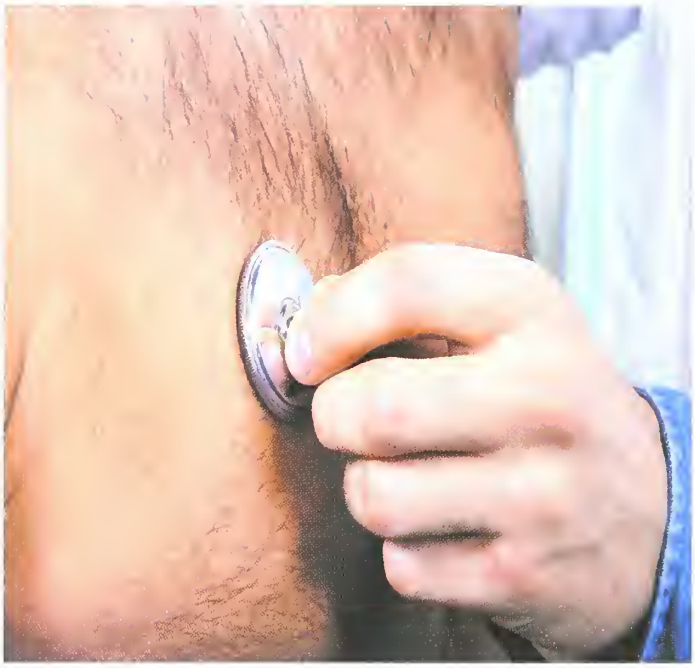
Shared care should aim to provide continuous patient support at all levels, both before and after discharge from hospital. This could require specialist input from a number of professionals: cardiologist, geriatrician, heart failure nurse, pharmacist, palliative care team, physiotherapist, district nurse, psychologist, dietician, GP and social services.

The heart failure nurse is likely to take the pivotal role in any such system, with responsibility for:

- educating patients and their family about the importance of self-monitoring of body weight
- recognising signs and symptoms of worsening heart failure (dyspnoea, orthopnoea and nocturnal diuresis)
- explaining the impact of heart failure on social activities
- emphasising the importance of influenza vaccination
- monitoring electrolyte balance and kidney function
- initiating non-pharmacological treatment
- adjusting doses of drugs such as ACE-inhibitors, diuretics and beta-blockers.

Given that heart failure is particularly prevalent among elderly people who are likely to have a range of concomitant disorders for which they may be taking other drugs, there is great potential for pharmacists to play an active role in the shared care team. This may be by:

- liaising with the GP/specialist nurse about treatments
- arranging for the use of compliance aids where necessary
- ensuring patients understand how and when to take medication
- arranging for repeat scripts to be ordered and delivered
- ensuring the patient is prescribed an appropriate dose of necessary medications
- monitoring for treatment side-effects and any adverse reactions
- monitoring for any problems the patient may be experiencing.



**Multidisciplinary care is vital when dealing with affairs of the heart**

## Drugs to be avoided in heart failure

Some drugs should be avoided in patients with heart failure. Avoid those that:

- increase fluid retention (NSAIDs and corticosteroids)
- interact with heart failure medication to increase the risk of renal failure (NSAIDs and lithium)
- decrease the strength of cardiac contraction such as verapamil and diltiazem, nifedipine, class I anti-arrhythmics such as mexiletine, propafenone and flecainide
- tricyclic antidepressants that increase the risk of arrythmias. Heart failure patients are prone to arrythmias particularly in the context of electrolyte abnormalities, which can be worsened by diuretic therapy

References available on request

*C&D is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001.*

# Where the pharmacist fits in the NSF for Coronary Heart Disease

Despite the availability of effective drug treatments in recent years, successive surveys suggest that many interventions such as ACE inhibitors and beta-blockers are not routinely used by GPs.

Even when effective drugs are prescribed, they are often used in low doses that have not been shown to be effective.

Furthermore, assessments of current service provision suggest there is considerable potential to improve the quality of care provided for people with heart failure and reduce the variations in service provision that may follow from geographical, gender, age and ethnic considerations.

Heart failure, therefore, is one of the seven major areas that has been addressed in a National Service Framework for Coronary Heart Disease. The NSF is likely to cut across a number of organisational boundaries. In particular, it will require effective liaison between primary and secondary care teams.

Ideally, there should be clear protocols specifying indications and routes of referral within the local network of cardiac care. They should be consistent with the local health improvement plan and long-term service agreements.

In primary care, this will involve the development of systematic guidelines, perhaps based on existing CHD registers, to ensure that patients with heart failure are identified and investigated.

It will also involve more effective delivery of care at the primary/secondary care interface, perhaps by means of:

- 'outreach' follow-up of those patients who have been admitted to hospital with heart failure to continue the education and support begun before discharge
- multidisciplinary support in the community for patients with established heart failure, together with home-based interventions with access to social care and the local palliative care team for support and advice as needed
- community or hospital-based 'heart failure clinics' delivering multidisciplinary care.

Whichever service models are put in place, PCGs, NHS Trusts and health authorities will be set a series of 'milestones', indicators of progress towards achieving the ideal standards of care set out in the NSF. It is also likely that the National Institute for Clinical Excellence will commission a method for clinical audit for heart failure care.

The NSF is likely to have major financial and organisational implications for each PCG, not least in the likely additional drug costs. Whether any additional funding is to be made available for its implementation is not yet clear.

Community pharmacists should ensure that their medicines management skills are put to best use in developing appropriate implementation policies.

## ACTION PLAN

1. Try to identify any of your patients who suffer from heart failure. Use the article as a source but also try to find other source material.
2. In your practice workbook list (in tabular form) their drug treatment. In the second column note the drug's action and in the third column note potential drug/drug interactions.
3. Using your heart failure patient list, note how you can follow up the management of their condition.
4. What symptoms are likely to be presented by patients with heart failure which they attribute to a self-limiting minor condition? They may ask for OTC medication which is inappropriate. Develop appropriate questions/limits which will protect your heart failure patients from harm. Add these measures to your protocol for your medicine counter assistants.

# Herbal concepts

Diana Austin, a medical herbalist at the Maple Leaf Clinic, explains some aspects of medical herbalism, and how her practice benefits from liaisons with other health professionals

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1159), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* MAY 6, PROVIDES ONE HOUR'S CONTINUING EDUCATION

## OBJECTIVES

- To understand the role and practice of a medical herbalist
- To distinguish between the different types of herbal practitioner
- To recognise the treatment benefits offered by herbal remedies
- To be aware of possible risks from taking some herbal products
- To be able to advise customers more effectively on herbal remedies

Herbal remedies, once the stock in trade of the 19th century pharmacist, are undergoing something of a renaissance. But they have been overshadowed to such an extent by the might of the modern day drug industry that only a handful of herbal medicines remain in the *British National Formulary*.

Some Dickensian-sounding remedies remain, such as peppermint oil for the relief of IBS and abdominal colic, isphagula husk for treating constipation, and guar gum to help control blood glucose levels in diabetics, plus several other products numbering herbal extracts as their actives, such as Kamillosan ointment (chamomile extracts).

But as far as the over-the-counter trade is concerned, it seems customers can't get enough of them. Herbal remedies are now estimated to be worth about £38 million a year.

Media reports of research highlighting the effectiveness and apparently safe side effect profile of many herbal medicines, such as St John's Wort for the alleviation of mild to moderate depression and garlic for the lowering of blood cholesterol, have fired public demand. More and more doctors are also showing interest, too.

The headache for the pharmacist is knowing enough about these remedies to advise patients on such matters as herb-drug interactions, effective doses and contra-indications. One way around this problem is to develop closer links with practitioners of herbal medicine or 'medical herbalists' as they are known.

## Working together

My own experience as a qualified medical herbalist, based at the multidisciplinary Maple Leaf Clinic of Complementary Medicine, above the Maple Leaf Pharmacy in Twickenham, south-west London, has proved to me how mutually beneficial such links can be.

The pharmacy, owned by pharmacist Galen Rosenberg, who inherited the business from his father, has an excellent local reputation. Staffed by four pharmacists, it is open 365 days a year, runs a medicine delivery service and stocks a wide range of homoeopathic, herbal and nutritional remedies.

I have found it invaluable to consult pharmacists on drugs that my patients may be taking, about which information may be lacking from the succinct pages of *MIMS* or the *BNF*. In turn, they find it useful to consult me or refer customers to me for advice on which herbal (or nutritional) remedies are best for their health problem.

Likewise, the pharmacists' knowledge is invaluable to me when I need to know whether Piriton could cause paradoxical stimulation; how long SSRIs and mono-amine oxidase inhibitors remain in the system after a patient comes off them or even what the mechanism is behind constipation caused by opioid-containing compound analgesics, so I can prescribe the most appropriate herbal remedy.

Over the year I have been in practice at the Maple Leaf, talking to the pharmacists, they have got to know what conditions generally respond well to herbal medicines (these are probably digestive, circulatory and many gynaecological conditions). Now when customers with complicated or chronic medical problems ask if there is anything more natural they can take, they will often refer them to me.

I return the favour, as I make myself available in the shop one afternoon a week to offer free help and advice for those wanting guidance on the herbal approach to health problems or in buying OTC nutritional or herbal products. I sometimes gain new patients this way, too.

The aim of current legislation is to protect the public from misleading and unsubstantiated medical claims for herbal and nutritional supplements. A worthy motive, but unfortunately it has created a situation where the public – and sometimes the

*Continued on PVI →*

## Practice points

- *Which herbal sleeping remedy is best if a customer is depressed?* Valerian or passiflora is the herbalist's response, and avoid any remedy containing hops as this can deepen depression.
- *Which herbal remedies are good for sleepless children?* Chamomile, lime flowers, lavender or melissa. *Is raspberry leaf tea safe in the first trimester of pregnancy?* It should be reserved for the final trimester.
- *What is the difference between Siberian and Korean ginseng?* Siberian is for raising energy levels when a person has been under long-term stress, Korean is more stimulating and generally more suited to the elderly, and should be avoided by those with hypertension.
- *How long does St John's Wort take to have its effect?* About two weeks.
- *Should ginkgo be taken by patients on anticoagulants?* No.

Continued from PV

pharmacist – often have absolutely no idea what the product may be useful for, whether they are taking an effective dose and if there are contra-indications to the scores of herbal and nutritional products on the shelves.

The standard advice is to refer patients to their GP, but in practice, very few GPs know enough about herbal medicine to answer these questions. Choosing a herbal or nutritional remedy is a minefield for the poor consumer. Lack of information is just as dangerous as misleading claims.

With vitamins and minerals, the public now has recommended daily allowances (RDA), reference nutrient intakes (RNI), and estimated average requirements (EAR) to provide some guidance. But supplements come in different forms. Should you buy calcium as carbonate, citrate, or amino acid chelate? (Calcium citrate is proven to be better absorbed.) Do customers know to compare evening primrose oil products by the gamma linolenic acid content?

Herbal products can be just as confusing. A herbal supplement offering the equivalent of, say, 100mg of the dried leaf sounds a better deal than a more expensive one containing a 12:1 50mg leaf extract, but the latter is six times stronger.

## Treatment options

Treatment often includes dietary advice and lifestyle advice such as advice on relaxation, as well as medicine. For example, a patient might be told to avoid foods that provoke wind, in an attempt to calm down the digestive tract.

They are usually given a blend of herbs tailor-made for them. It might include a digestive tract carminative, a sedative herb to help with anxiety, an antispasmodic and a liver tonic to improve digestion.

The medicine is often given as a tincture, usually containing 25-40 per cent alcohol. Besides water and alcohol the only other ingredient is the extract of the herb.

Sometimes the whole herb is used, sometimes just the root, flowers, stems, seeds or fruits, depending on which part is considered to have the most active medicinal action.

The advantage of single herb tinctures is that they can be readily mixed in most cases, to provide a tailor-made remedy. Herbalists also prescribe herbal teas, ointments, creams, pessaries, suppositories and capsules.

Herbals are, for the most part, safe and can be regarded more as food supplements, for example, ginger, nettles, dandelion and garlic.

However, there are a few restricted herbs which under the Medicines Act 1968, can only be supplied by herbalists or doctors, and which have their maximum dose laid down by law, such as ephedra, and belladonna.

## CSM warning on St John's Wort

There has been concern recently about St John's Wort. Last month, the Committee on Safety of Medicines issued a warning about important interactions between the herb and certain prescribed medicines.

The CSM advised that St John's Wort should not be used with warfarin, digoxin, indinavir, oral contraceptives, cyclosporin and theophylline. New evidence suggests that the herb is an inducer of various drug metabolising enzymes. This may result in a reduction in blood levels and therapeutic effect.

## ACTION PLAN

1. In your practice workbook list at least ten popular natural products you stock. Against each list potential drug/natural product and drug/patient interactions.
2. Make all your staff aware of the potential problems associated with all natural products. Highlight potential serious problems. Pay particular attention to risk groups (pregnant women, diabetics, hypertensives).
3. In view of these potential problems do you think natural products should be controlled more tightly. Discuss this with your staff and professional colleagues.
4. Looking at say three products containing at least one common ingredient. Can you make sense of the various ways the potency is expressed? Explain to your staff how each product operates.

## Herbal benefits

The major advantage that herbal medicine offers is that it can be preventative. There is also a considerable gap in the market for products which offer more than just symptom relief.

For example, the herbal winter best-seller echinacea, the purple cornflower, is one of a number of herbs that can help potentiate the immune system. In the case of echinacea this is by stimulating phagocytosis.

Hawthorn is a wonderful heart tonic, and its bioflavonoids have been shown to relax and dilate the arteries, making it a good choice for patients with angina and hypertension.

Garlic contains an amino acid, alliin, which when cut or crushed is transformed by enzyme into allicin, which helps lower blood cholesterol and prevents clotting.

Ginkgo has been shown to improve poor cerebral blood flow and slow down the progression of early dementia.

Slippery elm, marshmallow, aloe vera juice and meadowsweet are excellent mucous membrane protectors for gastric irritation and heartburn.

In some countries in Europe, especially Germany, herbal medicines have been absorbed into conventional medicine. There, doctors are just as likely to prescribe St John's Wort as a conventional anti-depressant. As the volume of medical research into herbal products continues to grow, the medical profession may soon start to take herbal remedies on board once again. Some are already working more closely with herbalists.

## Training and practising as a herbalist

To train to be a medical herbalist and to be recognised by the largest professional body in the UK, the National Institute of Medical Herbalists, normally requires five years' academic study leading to a BSc in herbal medicine, validated by the University of Wales, Central Lancashire or Middlesex University. Shorter courses are available for health professionals.

Founded in 1864, the Institute is committed to promoting and maintaining high standards of education and training for its members. Core subjects studied by students of herbal medicine include anatomy, physiology, pathology, diagnosis, pharmacology, pharmacognosy, botany, *materia medica*, and nutritional and herbal therapeutics.

As well as study assessed by year examinations, herbalists are required to complete 500 hours of clinical training in an approved clinic. The final clinical exam requires a student to take the case history of an unknown patient, perform a clinical examination and prescribe a herbal remedy, all in the presence of two experienced medical herbalists and a doctor (in my case a senior registrar physician at London's St Thomas' Hospital).

Members of the NIMH must also adhere to a Code of Ethics and Disciplinary Code. Unlike homoeopaths, with whom they are often confused, herbalists in the western tradition undergo much of the same training as conventional medical students. They learn modern clinical examination techniques, taking blood pressure, using a stethoscope to listen to the chest, abdominal, respiratory, cardiovascular examinations and are taught how to carry out simple urine tests.

What herbalists have in common with homoeopaths is that we treat patients holistically – looking always to address the underlying causes of ill health.

Herbalists are frequently confused with practitioners of Chinese herbal medicine. The Western and Eastern traditions have developed quite separately, with much of our knowledge coming from the ancient Greeks, old European herbals and native american medicine via the original European pioneers to the New World.

However, it is surprising how many of the same herbs Eastern and Western practitioners use, and often for similar health problems. Where we differ is that Chinese herbal medicine uses an entirely different method of diagnosis. It relies, to a large extent, on examining the tongue and feeling the pulses in the wrists. This technique is claimed to reveal how the body's energy force, or 'chi', is flowing along its channels or 'meridians'.

## A typical day

A typical day at my practice may see patients with irritable bowel syndrome, glue ear, menopausal problems, or a patient with secondary cancer seeking advice to help cope with the side effects of chemotherapy.

The first consultation lasts about an hour and the follow-up consultations about half an hour. A careful case history is taken of the current problem, previous medical history, the diet, how the patient sleeps, and how much they exercise, relax, drink or smoke.

They are questioned on each of their body systems: nervous, gastro-intestinal, respiratory, urinary and cardiac, as well as the health of their skin for signs and symptoms of undiagnosed pathologies.

The herbalist then looks to treat the underlying cause.

## Making contact

Medical herbalists should carry the letters 'NIMH', which stand for National Institute of Medical Herbalists, after their name.

To get in touch with a qualified medical herbalist in your area, look in the Yellow Pages or contact The National Institute of Medical Herbalists, 56 Longbrook Street, Exeter, Devon, EX4 6AH, tel: 01392 426022.

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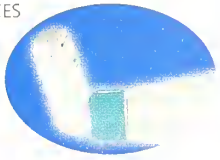

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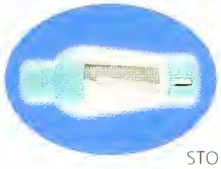

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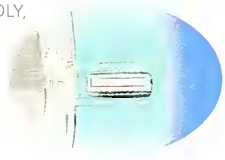

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# Down and out

## 1996

- Communication and the Pharmacist (1001)
- Rheumatoid Arthritis (1002)
- ACE inhibitors (1003)
- The Endocrine System (1004)
- Sleep Disorders (1005)
- Pituitary Problems (1006)
- Croup (1007)
- Harmonal Contraception (1008)
- Schizophrenia (1009)
- Psoriasis (1010)
- Constipation (1011)
- Methadone (1012)
- Methadone Supervision (1013)
- Beta-blockers (1014)
- Cystitis (1015)
- Palliative Drug Therapy (1016)
- Responding to Symptoms (1017)
- Drug Interactions Part 1 (1018)
- Drug Interactions Part 2 (1019)
- Malaria (1020)
- Headache (1021)
- Drugs in Sport (1022)
- Indigestion pt1 (1023)
- Sexually Transmitted Disease (1024)
- Cannabis (1025)
- Indigestion pt2 (1026)
- Diuretics (1027)
- Eating Disorders (1028)
- Coughs & Colds pt1 (1029)
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- Chinese Herbal Medicine (1031)
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- Hallucinogens (1033)
- Amphetamines (1034)
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- Lower Back Pain (1037)
- Myalgic Encephalamyelitis (1038)

## 1997

- Calcium Channel Blockers (1039)
- Stoma Care (1040)
- Dry Skin Problems (1041)
- Parkinson's Disease (1042)
- Lice & Scabies (1043)
- Alcoholism (1044)
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- Constipation (1046)
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- Nappy Rash (1066)
- Erectile Dysfunction (1067)
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- Mediterranean Diet (1070)
- Pneumococcal Infections (1071)
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## 1998

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- Benefits of Exercise (1079)
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- Anticoagulants (1082)
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- Enteral Feeds (1087)
- Whiplash (1088)
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- Thyroid Gland (1090)
- Angiotensin II Antagonists (1091)
- Stroke (1092)
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## 1999

- Phobias (1113)
- Antibiotic resistance (1114)
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- Heroin (1149)
- Auto-immune disarders (1150)
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- Chronic Daily Headache (1153)
- Endometriosis (1154)
- Transplants (1155)
- Asthma triggers (1156)
- Evidence-based medicine (1157)

Monthly MCQ papers for 1999 are numbered as follows. The codes apply for each month (the last two digits correspond to the last two digits of the first learning module which the MCQ paper covers):

| | |
|---|---|
| January | 2113 |
| February | 2116 |
| March | 2119 |
| April | 2122 |
| May | 2125 |
| June | 2128 |
| July | 2131 |
| August | 2134 |
| September | 2137 |
| October | 2140 |
| November | 2143 |
| December | 2146 |

All recently published CPP accredited Pharmacy Update modules can be found on the *C&D* internet site at: *www.datpharmacy.com*


## PHARMACYupdate: distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, *C&D*'s readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the May 6 issue, which will cover this week's CPP-accredited modules, together with those in the April 15 issue.

The MCQ paper for the March modules will be enclosed in next week's *C&D* covering:

- Transplants (1155)
- Asthma triggers (1156)
- Evidence-based medicine (1157).

A foxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

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**erences:** 1. Kelley MT, Walson Edge JH *et al.* Clin Pharmacol Ther 2; **52**: 181-9. 2. Sidler J, Frey B, Flocher K. Br J Clin t 1990; **44**(Suppl 70): 22-5. Walson PD, Galletta G, Braden NJ Clin Pharmacol Ther 1989; **46**: 4. McIntyre J and Hull D. Arch Childhaod 1996; **74**: 164-7.

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# HOW much longer lasting than paracetamol?

**Up to 2 more hours![1-3] Imagine finding a paediatric medicine for fever that could act for this much longer than paracetamol[1-3]**

Nurofen for Children Sugar Free is an orange flavoured suspension containing ibuprofen, which reduces high temperatures for up to 8 hours from a single dose.[1] Importantly, ibuprofen has been shown to be as well tolerated as paracetamol in young children throughout the licensed age range.[4]

Recommend Nurofen for Children Sugar Free from six months of age and let all the family enjoy the difference.

**A logical choice**


Contains Ibuprofen

Scottish contractors are facing major changes to their practice. George Romanes, SPGC chairman, updates Steve Bremer on developments in Scotland

# Stepping into the unknown

Scotland could have full electronic transmission of prescription data within five years. Virement schemes are threatening to fragment the pharmaceutical service in Scotland. And there is £0.5 million of funding for pharmaceutical care services to be allocated. When George Romanes, chairman of the Scottish Pharmaceutical General Council, says, "there's a lot to discuss this year", he is understating the scale of developments facing Scottish contractors.

Mr Romanes admits that "we are stepping into the unknown" on the issue of electronic prescribing. But the initiative has already reached a "halfway house" with the introduction, in April or May, of optical character reading at the Pharmacy Practice Division. This will mean that virtually all prescriptions will be priced electronically, without the need for operator input.

Electronic transmission is vital if pharmacists are to become more involved in repeat prescribing. "We can't move forward on repeat dispensing systems through pharmacies with a paper based system," says Mr Romanes. Doctors are also keen to see a system operational. "It's the one piece of their workload that they feel we could help them with."

Optical character recognition should not make much difference to contractors' payments. Contractors are already dealing with the modified prescription form, but there are still problem areas that need to be ironed out. These include forms containing more than three items, and endorsing machines that don't line endorsements up with prescribed items.

A group set up by the Scottish Executive has been looking for several months at two or three possible models for the introduction of full electronic prescribing. This may be an opportunity for Scotland to steal a march on England and Wales on IT issues. The Scottish Executive has promised £4m of funding to develop improved electronic links.

Of the many changes facing contractors, the proliferation of virement schemes is the issue concerning pharmacists most. Health boards and Primary Care Trusts want to explore the central purchasing and supply of certain products normally supplied through pharmacies, such as incontinence products and flu vaccines. They want to take money from the Primary Care Pharmaceutical budget and hope to make savings.

George Romanes wants to see stability come into the service

This may result in items such as incontinence pads, oxygen and medicines not all being available from the same source. Mr Romanes is concerned at this fragmentation of the pharmaceutical service. "We're keen to see the total pharmaceutical service preserved. We see this as the start of the erosion of the total pharmaceutical package."

Centralisation could actually raise costs, claims Mr Romanes. With the VAT implications (because prescriptions are VAT exempt), and setting up of the necessary supply infrastructure, costs may be higher than at present. Health boards are only interested in services that they believe are profitable, and will leave contractors with those that are not. "I don't want to see cherry picking of services," says Mr Romanes.

One of SPGC's biggest achievements since Mr Romanes became chairman in May 1998 is the allocation of £0.5m ring-fenced funding to develop new pharmaceutical care services (see *C&D* November 13, 1999, p4).

This money shows that the Scottish Parliament is committed to pharmaceutical care, or at least to the establishment of it. "It won't allow a huge amount of schemes to work, but it's a start. We can then assess the impact that pharmacy can have. It's a toe in the water exercise, at least."

Details of services are currently being finalised and they will be up and running by the spring. Each PCT has a share of the money according to the number of contractors in its area. PCTs, in consultation with local contractors, will choose who operates the service.

Could this be the way forward for pharmacists' remuneration? "There has to be a focus on the patient more than just the medicines, but it has to be remembered that we mustn't disassociate ourselves from the fact that the supply function will always be a core function," says Mr Romanes.

This is recurring money. As long as the schemes are effective, money will not be withdrawn and Mr Romanes hopes the amount may even be subject to an uplift next year. The scheme will be evaluated in six to 12 months' time.

"There's a lot of scope to develop new pharmaceutical care schemes, particularly with the ageing population. It would be good if all pharmacists could spend time reviewing elderly patient's medication."

Another novel pilot scheme about to be launched involves the use of a "community pharmacy prescription form" that will allow pharmacists to prescribe P and GSL items to exempt patients via the NHS. A formulary of drugs for minor ailments is currently being drawn up, focusing on ten therapeutic areas. These include head lice treatments, coughs and colds, and anti-fungal creams. The project will be similar to one that took place in Bootle, "but we are tartanising it a bit". Results from the Bootle scheme will be published shortly.

An additional benefit of the scheme is that it may need patient registration to be effective. The year-long pilot will be running in two areas by the summer. About six to eight pharmacies will be involved.

Community pharmacy practice research has also benefited to the tune of £50,000 with grants from the SPGC Research Trust, of which Mr Romanes is a founder member. Two projects are ongoing – one involves electronic prescribing and the other is looking at pharmaceutical care in coronary heart disease.

One thing Scottish pharmacists have in common with their English counterparts is a lack of pharmacist representation at LHCC, or PCG and PCT level. This has serious implications for Scottish pharmacists because PCTs have control over the devolved pharmacy budget of £5-6 million (out of a Global Sum of £7-5m), and also over determining pharmacy contract applications (see *C&D* September 18, 1999, p7).

SPGC is lobbying hard to get more pharmacists at PCT level. Because Trusts are only in their first year, there are bound to be teething problems. "Until these organisations 'bed in', they don't realise what skills they are missing," says Mr Romanes.

Pharmacists could provide some of these missing skills in the form of both formulary and medicinal knowledge, and business acumen.

"Pharmacists are the only people who invest huge sums of money in providing an NHS service so they've got a vested interest."

There are seven services paid for from the devolved budget and negotiated locally:

- recognised collection and delivery schemes
- rota services
- domiciliary oxygen therapy
- methadone dispensing
- advice to nursing homes
- disposal of unused medication
- needle exchange.

In an attempt to improve the running of LHCCs, the Scottish Executive has organised three seminars on the subject. A report from these will be issued at the end of spring or in the early summer, with points to be actioned by the autumn. "Where there's a problem it's often just a lack of communication. With improved communication and representation, things work more smoothly." Smaller LHCCs work more effectively, claims Mr Romanes, because communication is easier.

**"There could be up to 300 Scottish pharmacies at risk from the loss of RPM"**

While devolution is still at an early stage, first impressions are positive. "There seems to be a willingness [among MSPs] to try new ways of working. There's a realisation now that pharmacy has an important role to play."

When the Scottish parliament has become established, practice north of the border may diverge significantly from that of colleagues in England and Wales. But as yet, no more money has been made available. The Scottish Executive has kept a fairly tight rein on spending, as it does not want to be seen as "profligate".

Since devolution, SPGC has arranged several meetings with MSPs. "It's important that we keep an active liaison going," says Mr Romanes. "It's not so much lobbying as giving information. It's important to keep MSPs briefed." Scottish pharmacists can sometimes be "too canny" and reluctant to promote themselves, he believes.

To keep in touch with colleagues at PSNC and the Northern Ireland Pharmaceutical Contractors Committee, tri-partite talks are held about twice a year. SPGC has more in common with the PCC than with PSNC, because "population is the main driver. It's a lot easier to change a system that applies to five million people than 55 million".

Following the activity of Jim Gee in England, a fraud unit is being set up in Scotland. Mr Romanes does not expect a Scottish 'fraud tsar' to vastly reduce prescription fraud. Point of dispensing checks are already well established in Scotland, having started ahead of England and Wales in summer 1998. Since the introduction of these checks in Scotland, an additional £9m has been collected in prescription charges.

A Scottish drug tsar has already been appointed (see *C&D* March 1, p6). With over 300 Scottish pharmacists involved in methadone supervision, James Orr is certain to influence their practice. There are too many prescriptions for large volumes of methadone, and not enough are being supervised, says Mr Romanes. There will be a tightening up of take-home dosages and increased supervision, he believes. And there could be more needle exchange schemes.

This presents another opportunity for pharmacists to increase their role. "We are keen to participate in any schemes that keep methadone off the streets and help minimise the number of deaths due to drugs. A sticking point may be resources because it's time consuming, but there's a network of 1,140 pharmacies so there's no reason why we aren't up to the task."

The possible loss of resale price maintenance is one of the biggest issues facing pharmacy, says Mr Romanes. "It would be a tragedy for patients – they will save a few pence a week but they may lose their local community pharmacy. It could impact very adversely on local communities."

There could be up to 300 Scottish pharmacies at risk. And the Essential Small Pharmacies Allowance would not be sufficient to cover the loss of RPM. "A lot of the smaller pharmacies will fall through the net and be lost to the system."

Although it is early to make predictions about this year's remuneration settlement, which is expected in the summer, Mr Romanes expects improvements to the Essential Small Pharmacy Scheme. Also to be discussed are clinical governance and virement projects. Mr Romanes is hoping to get some protected time for educational issues and risk management. "There's a lot to discuss this year," he says.

Mr Romanes will remain as chairman until May next year. There is plenty that he wants to achieve before then. "I'd like to see some stability coming into the pharmaceutical service to allow us to plan for the future." He wants point of dispensing checks recognised, and to see more consulting rooms. "But most of all, I'd like optical character recognition to run smoothly and pay contractors accurately."

الصيدلة - النظرة الجديدة
*Pharmacy - A New Perspective*

# Strength through unity

More than 300 delegates are attending the Vantage Convention in Dubai this week, the highest figure since 1991

Last year had been difficult for all pharmacies, who had to cope with generic shortages, and an increasingly competitive OTC environment. "All this meant it was a year of hard graft, but it was a learning experience," said Steve Dunn, AAH Pharmaceuticals managing director, as he opened the Convention.

Pharmacies are also coping with extensive changes, such as the development of primary care groups and trusts and - on the horizon - the outcome of the resale price maintenance court case in October.

"With 100 PCGs becoming PCTs by the end of the year, pharmacists face either a tremendous opportunity or a tremendous threat depending on how they view the situation," he said.

"These radical changes in the market place are likely to be best met collectively rather than individually, and as Vantage is the largest symbol group in the market, members could not have chosen better in terms of strength and support."

# Vantage values networking

A forum for pharmacy support - the Vantage professional pharmacy network - has been launched this week by AAH Pharmaceuticals.

The network is designed to support Vantage members by providing links with like-minded colleagues in various areas. For example, it will help those who want support from pharmacists to provide services for primary care groups and trusts, and it will put pharmacists in touch with colleagues already involved in initiatives such as healthy living centres.

Mandeep Mudhar, AAH's professional services manager, said: "We will also arrange for you and fellow Vantage pharmacists to get together in your PCG and look at how you can jointly provide new services."

Vantage members who want to be involved in the network should contact Mr Mudhar at AAH's headquarters.

Mr Mudhar said pharmacists had to be prepared to change quickly to keep up with the fast moving professional environment. Apart from meeting the needs of PCTs/PCGs, pharmacists had to decide what they wanted to do with e-pharmacy.

The latest developments, such as Allcures' permission to distribute pharmaceuticals through a third party distributor, meant that the essence of pharmacy's role - pharmacy supply and delivery - has been "blown out of the water".

E-pharmacy has made all pharmacists sit up and realise that "a pharmacist is not visually or physically required to sell medicine or deliver medicines".

AAH's customers are faced with two choices: "You can bury your head in the sand, forget about all the changes - and surely and slowly you will perish. Or you can adapt and embrace change, learn from other retailers, acquire their strengths while enforcing your own as that of a local community healthcare provider trusted by your customers," he said.

Michael Ward, Gehe UK's chief executive, said e-commerce had nothing to do with pharmacy if you gauged it on the profession's one-to-one relationship with customers. "Pharmacy is about quality of information, quality of advice - having your customers for years and being able to give them advice."

If the Government wants the NHS to save money, he added, it could start by helping pharmacists to tighten control over the £1 billion that is wasted when pharmaceuticals are not properly taken, or not taken at all.

However, Mr Ward sees huge possibilities for e-commerce in business-to-business relationships. AAH will open these up to its customers.

Meanwhile, pharmacists' primary challenge is to give customers the best service, particularly as customers are becoming more demanding. Mr Mudhar said Vantage members were in an ideal position to meet all these challenges by adapting and changing.

**Mandeep Mudhar, AAH's professional services manager: providing links**

## AAH launches Vantage Silver Pharmacy awards

AAH Pharmaceuticals has launched the Vantage Silver Pharmacy awards scheme for Vantage members to celebrate the symbol group's 25th anniversary.

Five awards will be presented during the year for the categories: information technology, professional services, healthcare, marketing and pharmacy chain.

Each winner - to be announced every other month - will receive a silver trophy, £1,000, local and national PR, and entry into the final for the Overall Pharmacist of the Year. The overall winner will receive £5,000.

IT will be the first category to be judged and Vantage pharmacies can nominate themselves by filling in an entry form, which will be in the May issue of *Vantage News*. The applications must be submitted by May 15.

Steve Dunn, AAH's managing director, said the awards were more than a celebration of Vantage's success. "We're demonstrating that pharmacies need to drive change in the market place and that they're striving constantly for self-improvement," he said.

**IN BRIEF**

- AAH had refreshed 700 Vantage pharmacies by the end af 1999 and expects ta have 1,300 refreshed pharmacies by the end af this year.
- Over 400 stores have taken up the phatashop offer this year and its sales target is mare than £1 millian.
- The Vantage baby bag promotion sold over 2,000 units in its first manth.

## AAH changes corporate logo

AAH

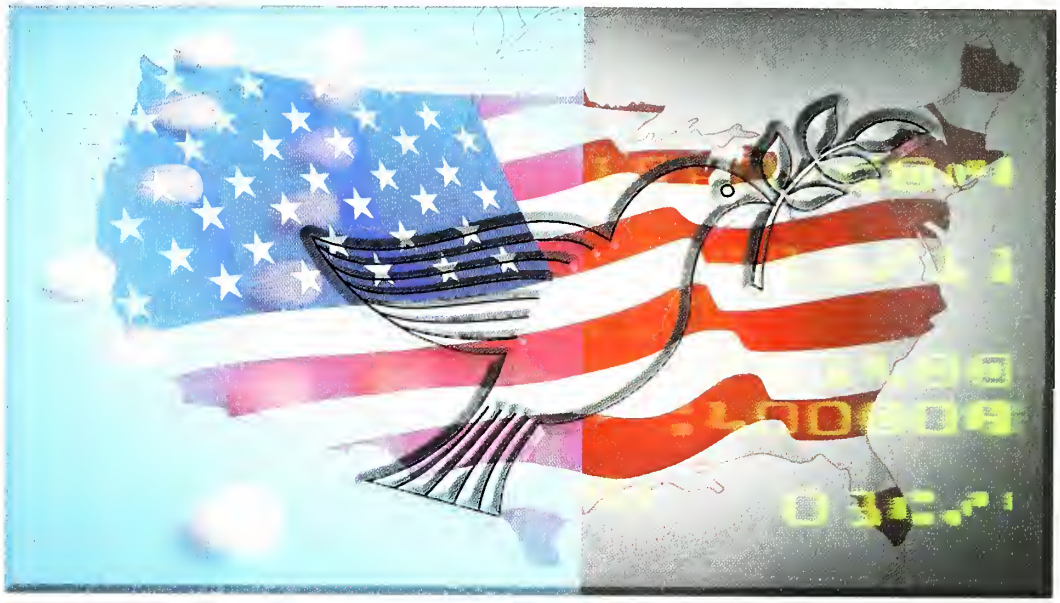
AAH Pharmaceuticals has unveiled its new logo which was developed by McCann-Erickson, following close consultation with the wholesaler's marketing team.

Steve Dunn, AAH's managing director, said the logo indicated that in a changing market place AAH was continuing to adapt to meet its customers' needs. "The logo is a clearly visible sign that AAH Pharmaceuticals is moving forwards and is more dynamic, more challenging and faster on its feet than ever before," he said.

Some features of the previous logo have been kept to remind AAH's customers that certain key aspects of the business, such as its product ranges, focus on pharmacy customers, and level of service, will not change.

US on-line pharmacies are seeking links with 'bricks and mortar' chains to prosper

# Cyberspace olive branch



Healthcare sites are the most popular on the web in the US, yet relatively few Americans are purchasing their medicines on-line. Fewer than six million Americans used this method early last year, compared with around 17.5 million who went on-line for health and medical information.

As around 89.5 million American adults take prescription drugs alone, the US on-line pharmacy market still has a lot of ground to cover. Annual on-line sales are around $500 million and are expected to reach $3 billion-$4 billion by 2002, which is still minuscule compared to total US medicine sales of $120 billion.

From another perspective, the market has undoubtedly moved fast, considering it sprang up only in 1998.

Consumers can choose between around 1,500 web sites selling prescription medicines: some are affiliated to nationwide 'bricks and mortar' chains, such as *CVS.com* (part of the CVS/pharmacy); others are purely on-line ventures, like *Rx.com*, that are licensed to ship prescriptions to every US state; a few distribute products through a network of independent pharmacies, such as *CornerDrugstore.com* and *Clickpharmacy.com*; and there are numerous small scale operators.

## I want it now

Tony De Nicola, a US industry consultant, feels on-line pharmacies will not survive unless they establish links with bricks-and-mortar drugstore chains. He says: "The biggest problem is immediacy – if you want medicine you want it now, so you'd go to your doctor, get a prescription and pop into your local drugstore, instead of waiting three to four days for your internet order to be delivered."

On-line pharmacies already linked with pharmacy chains offer this immediacy – their competitors are following suit and Mr De Nicola reckons all the major players will have similar links by the end of this year.

Healthcare insurance is another complication. Mail order specialists, which are registered with healthcare insurance providers, account for practically all prescription deliveries. On-line pharmacies will continue to attract little prescription trade until they have similar registrations.

That explains why *PlanetRx.com* has signed a deal to collaborate with Express Scripts, the US' third biggest mail order prescription business.

Practical partnerships aside, on-line pharmacies' biggest attraction, according to Mr De Nicola, is the access they provide to huge healthcare databases. And they are extending that access. CVS/Pharmacy, for example, has linked up with Healtheon/WebMD, an internet company that connects GPs and consumers to the healthcare industry. Under the complex deal *CVS.com* will be promoted exclusively in Healtheon/WebMD's web sites, and in the healthcare channels of Healtheon/WebMD partners, such as Excite@Home and the Microsoft Network. Healtheon/WebMD's web site network will also process the prescriptions of both CVS' 4,100 bricks and mortar pharmacies and those of its on-line service. Both companies expect the deal to generate revenues by attracting more customers and advertising/sponsorships.

"On-line pharmacies can attract lots of visitors by offering [healthcare] links, but it's not enough to drive big business to them," says Mr De Nicola.

Competition between major on-line pharmacies is so fierce that there is little to differentiate them. Practically all have the facility to take orders and liaise with pharmacists on-line around the clock, every day of the year. Discounts of up to 40 per cent on prescription and non-prescription medicines; and free deliveries anywhere in the US within five to seven working days are also typical.

*Rx.com*, based in Austin, Texas, moved ahead of the pack in February when it introduced a pilot scheme that offered free, same day delivery for its Austin customers. The scheme is expected to be rolled out throughout the state and, ultimately, across the US.

Meanwhile, US authorities are clamping down on rogue on-line pharmacies. In most US states a GP is not allowed to prescribe drugs to a patient outside his or her state. Some web sites have argued that when a patient fills in an on-line prescription form, the patient is in the state where the web site is located. This argument has apparently not yet been tested in a US court and the American Medical Association is working with regulators to develop legislation. It is particularly concerned about web sites that allow customers to buy prescription products without proper consultation and diagnosis.

## Certified sites

The Food and Drug Administration is seeking powers to fine such traders up to $500,000 (£305,000) and it is setting up a system to certify sites.

It has also developed a search engine to rapidly scan and pinpoint sites illegally selling medicines.

One US pharmacy authority has taken a different route by creating a seal of excellence for on-line pharmacies. The National Association of Boards of Pharmacy, which helps develop and enforce pharmacy standards, introduced the VIPPS seal (Verified Internet Pharmacy Practice Sites) last spring.

Pharmacy web sites displaying the seal will have satisfied a number of requirements, such as proving they are licensed with every pharmacy board in the states they deal in, and they must have provided a detailed explanation of how medicines are dispensed at the practice site. VIPPS is voluntary and has been adopted by four of the biggest on-line pharmacies.

VIPPS is unnecessary, says Mr De Nicola, because few consumers order prescriptions on-line.

Overseas sites present a potentially bigger problem because they are difficult to control. Last year the internet had around 200 such sites.

US authorities are concerned that consumers in search of medicinal 'bargains' may end up buying substandard products, which have not been approved by the FDA, and may even be contaminated or counterfeit.

It wants greater co-operation between governments to deal with this. But some governments, particularly in eastern bloc/third world countries, have other priorities.

Mr De Nicola compares the FDA's task to stopping the flow of illegal narcotics. "If you crush one source, another immediately springs up."

# Olibra set-back for Scotia as results are unveiled

Biotechnology company Scotia Holdings has released preliminary results for the year ended 31 December 1999, just as it emerged that Maval yoghurt, the first marketed food to contain the firm's Olibra ingredient, was being withdrawn on cost grounds.

Scotia's total turnover for 1999 amounted to £6.3 million, compared with £18.6m in 1998, while gross profit fell by 38.4 per cent to £1.7m.

After an exceptional charge of £2.5m, overall losses attributable to shareholders for 1999 totalled £33.2m (42p per share), compared with £18.6m (23.6p per share) in the previous year.

Commenting on the results, Scotia's chief executive Dr Rob Dow said that "valuable progress" had been made in each of the company's four platform technology areas of: photo-dynamic therapy (PDT), satiety, reformulation technology and lipid biology.

Meanwhile, the decision by Sweden's second-largest dairy co-operative, Skanemejerier, to withdraw its Olibra-containing Maval yoghurt product was based largely on cost factors, it has emerged. Supermarket chains in Sweden, Finland and the UK are said to have found the product too expensive.

Scotia is currently in discussion with a number of potential new European partners.

The company is confident that it will secure a development partner for Foscan, a palliative treatment for incurable head and neck cancer, which was granted 'orphan' status in the US in 1999. Foscan accounted for 61 per cent of Scotia's £26.1m R&D costs last year.

# Numark rebate rockets by 117pc

The Numark rebate income for community pharmacists rose by 117 per cent in the final quarter of 1999, compared with the same period the year before.

Payments for the quarter totalled £1.7 million, versus £783,299 in 1998.

The growth is a result of continued investment in the brand and the Numark programme by its 1,350 shareholders.

Deputy managing director David Wood said the retail-owned company's strategy of differentiation was aimed at pharmacists as well as consumers: "There is no other community pharmacy group in the UK that offers pharmacists a quarterly income by being shareholders," he said.

Numark's Concept Pharmacy Programme, pharmacy assistant training schemes and consumer initiatives are increasingly well supported. The organisation currently represents 14 per cent of independent pharmacists in the UK.

# Celltech announces preliminary results

Celltech, one of Europe's largest biopharmaceutical groups, has announced preliminary results for the 12 month period to December 31, 1999.

Medeva, the in-market pharmaceutical business acquired by Celltech in January, achieved sales and royalty revenues of £281 million in 1999 compared with £309m in 1998 on a like-for-like basis. The reduction reflected a decline of almost 50 per cent in methylphenidate sales to £37m over the period, and exceptional UK reorganisation costs of £8m.

The results have also been adversely affected by 'difficulties' in the production of the company's influenza vaccination Fluvirin, sales of which declined to £15m, compared with £19m in 1998. Total operating profit before exceptional costs was £42m.

Celltech Chiroscience, another recent merger, achieved a turnover of £40.4m and a gross profit of £25.3m over the period. Excluding discontinued activities, revenues for the 12 months to the end of December 1999 reached £18m, principally comprising revenues from licences to the Boss patent. The company made an operating loss of £32.7m.

Celltech's integration strategy is expected to lead to significant annual savings amounting to £8m for Chiroscience, effective from the beginning of this year, and £15m for Medeva.

# Phoenix makes agreed bid for Norscot

Pan European health distributor Phoenix Pharmahandel AG & Co has made an agreed offer to acquire a controlling interest in Aberdeen-based Norscot Pharmaceuticals Ltd.

Norscot, which controls about 6 per cent of the Scottish pharmaceutical wholesale distribution market and has an annual turnover of more than £23m, will form a wholly-owned part of Phoenix Healthcare Distribution, bringing the number of its UK depots to 13.

Phoenix chief executive Dr Bernd Scheifele said the family-owned firm is committed to supporting independent pharmacy and will continue in the tradition that "all business is local".

"We believe in a decentralised organisational structure, with the distribution centres and subsidiaries being run as profit centres," he said. "In this respect the company will be no different to the others within the UK group."

Phoenix's financial backing and distribution network is expected to give Norscot "increased efficiencies and the strength to develop in the fiercely competitive British and European markets".

The purchase is conditional upon the management and staff of the company remaining in place.

Norscot managing director Duncan Cameron believes the offer is in the best future interests of staff, customers and shareholders alike. "I don't anticipate any loss of staff - if anything I expect the opposite to happen because there is a lot of business to be had in this neck of the woods," he said.

"There are obviously no guarantees, but Phoenix's idea is to keep everyone in place. I truly believe that is what they think and, certainly, in all the discussions we have had, that is what has come across."

The "power and muscle" of Phoenix will also enable Norscot to develop in new areas, said Mr Cameron. "The one area in which we haven't been able to compete against AAH and the like is in the funding of customers," he explained. "A customer who wants to buy a nice new shop could be faced with a £0.5m bill and we have been too small to offer very much help by way of a funding package in the past. But there is potential to buy shops in the area and now we are in a position to help in that respect.

"Alternatively, if there was no competition from our existing customers, then I suspect that Phoenix itself would be very happy to buy shops if the opportunity arose."

The acquisition will increase Phoenix's share of the UK market to over 10 per cent and confirm the company as the third largest player in domestic pharmaceutical wholesaling.

Sandy Young, chief executive of Phoenix Medical Supplies, said: "With the support of Phoenix and the local staff, I look forward to improving the range and quality of service to Norscot customers."

**Duncan Cameron, managing director of Norscot Pharmaceuticals Ltd: "There is potential to buy shops in the area and now we are in a position to help customers in that respect"**

Other firms in the Phoenix Healthcare Distribution group are: Birmingham-based Philip Harris, which has an annual turnover of £140m; Wales-based L Rowland & Co Ltd, annual turnover £120m; Foster Healthcare (including Hamilton Pharmaceuticals), total turnover in excess of £160m; and Border Chemists' Alliance, which has a turnover of £22m.

## COMING EVENTS

**APRIL 4**

Bury & District Branch, RPSGB, at Norton Grange Hotel, Castleton, Rochdale, 7.30 for 8pm. 'Internet applications for pharmacy'.

**APRIL 5**

South-west region RPSGB at BAWA, Southmead Road, Bristol. 'Atypical Antipsychotics' at 7.45pm. Buffet and coffee from 7.15pm.

**APRIL 6**

South-west region RPSGB at Crossmead Conference Centre. 'Atypical antipsychotics'. Buffet from 7.15pm.

Southampton & District Branch, RPSGB, at Primary Care Development & Resource Centre, Southampton & South West Hampshire Health Authority, Oakley Road, Southampton. 7.30pm for 8pm, with a buffet provided. RSVP Anne Friedli, tel: 01703 725464.

# Nucare buys its own 'distribution hub'

Nucare plc plans to supplement the services of its nominated suppliers following acquisition of the whole share capital of toiletry and OTC supplier Wakefield Impex Ltd.

Wakefield's Middlesex-based 10,000ft² warehouse and office facility will be used as a nationwide distribution hub for Nucare members.

Mahesh Shah, Nucare's sales and marketing director, said: "These facilities will enable Nucare to better serve its members for their core needs and we will work closely with manufacturers to promote their products and pass on to members some best buys as often as possible."

Barry Apostolou, products manager at Nucare, said the newly acquired warehouse would be used to store a range of products, including generics and parallel imports.

Although the acquisition inevitably raises questions over the potential for competition with Nucare's existing nominated suppliers, including AAH Pharmaceuticals and Sigma Pharmaceuticals, Mr Apostolou stressed that the new initiative was designed to supplement the services provided by these partners, and not to replace them.

Sales and marketing manager John Barklamb agreed. "Our members are spending their money in a certain number of areas and we believe there is a spending gap," he explained. "We are trying to fill that gap and, working closely with manufacturers, offer our members best terms."

Nucare promises 48-72 hour deliveries initially, but the installation of new systems and operating practices will speed up this process. "As more and more customers come on board, we will be able to put in the investment to make improvements in distribution," said Mr Barklamb.

In a separate development, Nucare has become a nominated trading partner of Sodexho Pass, the company that administers the Government's voucher system for political asylum seekers. Under the scheme, vouchers to the value of £50 per week per individual can be redeemed against food and other suppliers from nominated supermarkets and pharmacies.

Mr Barklamb said: "For Nucare members this creates a new sales opportunity as they are the only independent pharmacies able to participate in this scheme. Our members will inevitably see an increased number of customers entering their pharmacies in order to purchase goods and services in exchange for Buy-pass vouchers, thus increasing their turnover."

Window stickers are to be issued to Nucare members to indicate that they are a part of the Sodexho Pass retail network.

# Branded medicine supply to be scrutinised in DoH/ABPI study

The Government and the Association of the British Pharmaceutical Industry (ABPI) are undertaking a joint study to examine the extent of competition in the supply of branded medicines to the National Health Service.

The announcement follows negotiations last year on a new Pharmaceutical Price Regulation Scheme (PPRS), during which it was agreed that analysis of the factors influencing the dynamics of supply and use of medicines in the NHS was required.

The study will include an assessment of the scope, pace of change and practical impact of competition.

According to Richard Ley, of the ABPI, it will also look at the possibility of deregulation of the market: "The basic argument is that this is already a highly competitive market and the question is, therefore, how much regulation is actually needed."

Lord Hunt, government health minister responsible for the pharmaceutical industry, said: "It is important that we are properly informed of what is happening in the market place for branded medicines and how that affects the NHS, which spends annually some £7 billion on medicines."

An increasing proportion of NHS spending is on medicines; in 1993 this amounted to £4.5bn, rising to just under £7bn last year, representing annual growth of almost 9 per cent.

Lord Hunt continued: "The study will look at competition in both the in- and out-of-patent sectors for branded medicines and we hope to improve our understanding of the supply and demand of pharmaceuticals to hospitals."

The sensitivity of prescribing behaviour to price changes and the cost of medicines in other countries will also be assessed by the study. These results should be available in time for a PPRS mid-term review, which takes place in April 2002.

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# Train-spotter goes for gold

A train-spotting pharmacist who has collected a massive 25,000 locomotive and carriage numbers to win a 'Silver Rail' award, is planning a trip abroad to go for gold.

Having nearly exhausted the British rolling stock numbers, Arthur Fredrickson from Crewe is having to go abroad to collect another 25,000 so that he can claim his 'Golden Rail' certificate. Achieving this goal will also be a passport into the Chemin D'Or Club, an 'exclusive' European association of train-spotters extraordinaire.

Art, as he is known to his friend, has only recently taken up the hobby since he started locuming. Being based in Crewe inspired him to further his passing interest in trains and a love of numbers clinched the idea of train spotting. He recommends starting the hobby once spring is here. "I started last February and was pretty despondent as I stood on the end of rain-swept platforms with a flask of soup as my anorak soaked up the rain. But then, once the days grew brighter and warmer, I really got to enjoy being out of doors. There's a real camaraderie among us spotters and you get to see some really exciting carriages going past."

Besides Crewe, Art favours Clapham Junction, London Bridge Station (when Connex is running) and Doncaster. Despite being good for numbers, it can be essential to wrap up against the perpetual wind that seems to blow through that particular gateway to the north, he advises.

So where to go abroad? Eurostar can take him to Paris or Brussels, but Arthur is thinking that a more central European city, such as Berlin, might be good. He particularly likes the idea that Berlin is the interface between east and west, so expects to get some 'exotics' like Polish, Russian and hopefully Chinese goods trains passing through.

## Cool for cats

A pharmacist cat lover is hoping her own cat will take first prize in the 'Moggies', the cat-world equivalent of Scrufts, the Crufts for mongrels.

Felicity Canem of Wimbury, Wiltshire, has been an active participant on the non-pedigree cat show circuit for several years, and is now keen to see the national competition get as much coverage as the dog shows.

"People think I'm too catty when I say dogs don't deserve as much attention as they get," she laughs. "But I am a firm believer that your domestic moggy has much more character, intelligence and personality than those mutts which dog owners delight in manicuring and giving a fancy perm."

Her (hopefully) prize-winning non-pedigree puss, Twiggy, has free run of Felicity's village pharmacy and is well known to her customers. Twiggy gets on particularly well with those customers of a more nervous or worried disposition and Felicity reports that the prescribing of hypnotics, particularly nitrazepam, has fallen in the village as a result.

Until recently, Felicity was one of the few private female lion tamers with her own pride, and regularly did weekend shows for Papa Lazarou's Circus. However, she decided to give that up when injury costs became too much and also because too many of her tigers were being put down due to mange.

The Moggies takes place on April 23 at the Marble Pavilion Exhibition Halls in Purfleet, Essex.

**Potentially prize-winning Twiggy who has recently had her diet supplemented with cod liver oil to encourage a glossy coat. "She laps it up," says owner Felicity Canem**

## Through the square window …

**Detail from Queen Street Station, Glasgow**

A Lincolnshire pharmacist is set to join the coffee-table league with the publication of a glossy picture book.

'A Room with a View' is a collection of primary care pharmacist Joshua Ing's photographs. All the pictures have been taken out of hotel windows when Josh, who hails from Sollerby, has been travelling on holiday or for work. Shots range from the seafront at Cleethorpes, taken when he stayed at the Kingsway, to the slightly more exotic Queen Street Station (pictured), taken from room 104 at the Copthorne Hotel in George Square, Glasgow.

"Architectural shots really appeal to me," says Josh. "I think it is so important to have a room with a view, and it can often be worthwhile slipping the hotel receptionist a little extra just to make sure you overlook something interesting."

Joe got the idea when he heard that the producers of a remake of the classic Hitchcock movie 'Rear Window' wanted an on-set medical adviser. Although Josh was unsuccessful in getting the job, the film prompted him to use the pictures he has taken from hotel windows over the years.

He hopes the publishing date of the book will mean he is able to cash-in on the movie which has an STV release later this year. "It has been an exciting time. My publisher was very supportive and has helped me select the most interesting shots. I thought it would be a scrap book of memories, but I am pleased to think that now my work will be rubbing covers with the likes of *Hello* magazine."

Over the years Josh has acquired some impressive equipment for his hobby. Now that he is "creaming off a tidy sum" from the savings he makes to GP prescribing budgets, he has recently entered the world of digital imaging. The digital camera and computer set him back a few thousand pounds, but he sees that as an investment while there is still no VAT on books.

**We need your help. Do you recognise this man? We have been contacted by Chemisnaps, the photo developing service for pharmacy outlets, looking for the owner of this, admittedly, badly exposed film. A customer in Durham was given this film instead of one taken on her wedding trip to Puerta Vallerta in Mexico. Chemisnaps thinks the films must have got mixed up when a stray cow ran amok, crashed into the processing plant and upset a rack of drying negatives. The customer is putting on a brave face, says Chemisnaps. Although disappointed not to see her photos, she was intrigued by the shadowy figure lurking in the office. If her current fella doesn't cut the mustard she has designs on this chap. Chemisnaps is offering a reward. You can contact them on 01277 453665**

## All cleared for dinner – the real story

We are glad to be able to report that those guests reported missing from the official guest list at the PSNC dinner were all there in a good cause (**People** last week). RPSGB Council members Sid Dajani and Pat Hoare stepped in at the last minute to help a struggling LPC secretary who had 'lost' two pharmacists on his table at short notice, which was very obliging of them. And Alan Hunter? Well, he was an official guest of PSNC itself.

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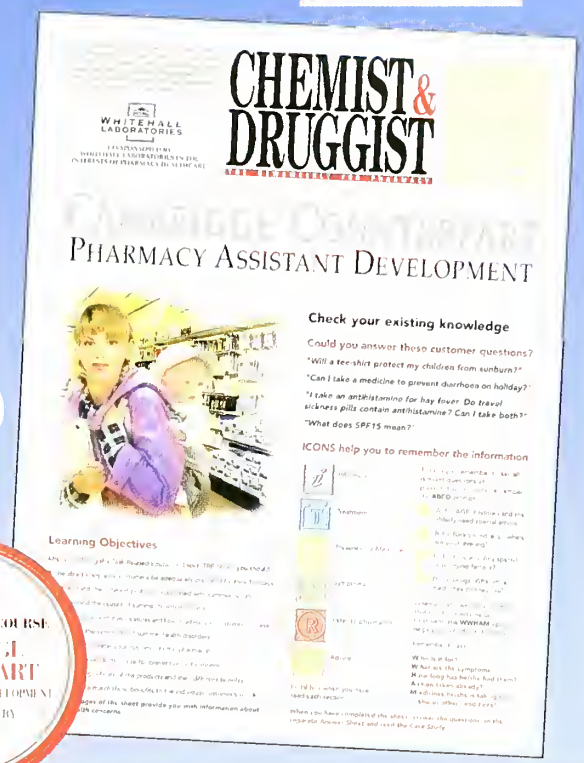


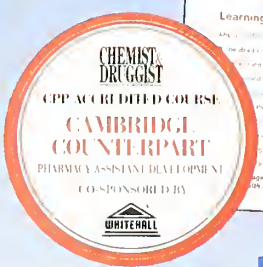


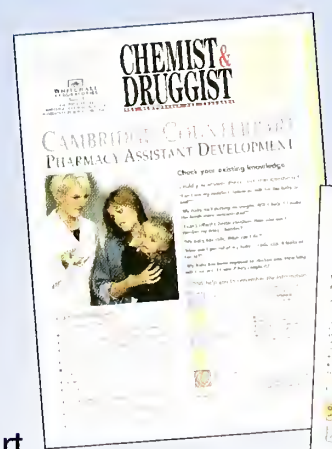


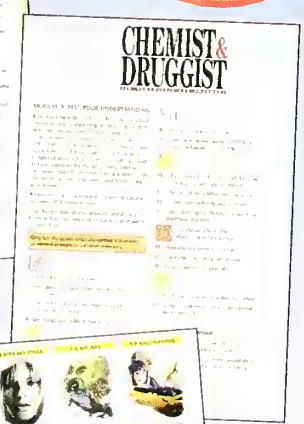


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**For further information contact John Skelton on 01732 364422**

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